MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH DEPARTMENTS

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AVAILABILITY OF PRIMARY CARE SERVICES UNDER MEDICAID MANAGED CARE: How 14 HEALTH PLANS PROVIDE ACCESS AND THE EXPERIENCE OF 23 SAFETY NET PROVIDERS AND THEIR COMMUNITIES

APPENDICES TO REPORT

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EXECUTIVE SUMMARY

Capitated Medicaid managed care more than tripled from 1993 to 1996, growing from 2.6 million to 7.7 million beneficiaries in just three years. This rise in enrollment is challenging many managed care plans to provide services in areas and for populations that they have not served before. Medicaid managed care enrollees tend to have health-care-seeking behaviors, health care needs, cultural values, health status, and transportation access that differ from other managed care enrollees. This study, funded by the Health Resources and Services Administration (HRSA) and conducted by Mathematica Policy Research, Inc. (MPR), investigates how managed care plans are providing Medicaid enrollees with access to primary care in inner-city and rural areas, and what effect their strategies to provide care are having on access to care for these communities and for traditional Medicaid-serving providers in those areas.

STUDY OBJJXTIVES AND METHODS

This study has three objectives:

- To describe both the strategies health plans use to generate access to primary care for the Medicaid population and the role traditional Medicaid-serving providers such as community health centers (CHCs) play in these strategies.
- To assess how different strategies influence access to primary care for the Medicaid population.
- To identify how these strategies are affecting traditional Medicaid-serving providers in a community.

The methods through which MPR achieved these objectives primarily include site visits to health plans, CHCs, and other traditional Medicaid-serving providers during April - December 1996, supplemented by analysis of data from the Federal Bureau of Primary Health Care on CHCs.

The 14 health plans we visited were selected because they are high-volume and growing Medicaid-serving plans. Operationally, "high-volume" and "growing" were defined as having 20,000 or more Medicaid enrollees in June 1995 and an increase of about 10,000 or more enrollees since 1993. Ten of 16 plans originally targeted agreed to participate, and four other plans were added. Of the 14 visited, 6 were Medicaid-dominated: Medicaid beneficiaries made up at least 75 percent of their enrollment. Three of the 14 were mixed-model plans with a staff-model component that had full-time physicians, and the rest were network/independent practice association (IPA) type plans, which contracted with providers in independent practice who were free to contract with other plans.

All plans but one are based in an urban area and all are located in the following eight states that varied in their approach to Medicaid managed care and in the competitive environment: California,

Colorado, Connecticut, Michigan, New York, Ohio, Pennsylvania, and Washington State. Washington State and Connecticut had mandatory Medicaid managed care programs at the time of our visits, and the markets we visited in the other states were all shifting from voluntary to mandatory programs, except for the one in Colorado.

The 23 CHCs and other traditional Medicaid-serving providers were selected from within the health plans' inner-city and rural service areas. Usually two of these providers were selected per health plan, or three were chosen in areas where the service areas of two study plans overlapped. Of the 23, 13 were CHCs, 4 were other federally qualified health centers (FQHCs), 4 were health departments that provided primary care, 1 was a rural health clinic in a high-poverty county, and 1 was a city-run health center.

STRATEGIES FOR PROVIDING ACCESS

In aggressively expanding their Medicaid service areas, health plans included underserved urban areas. One rural-based plan in the study and three plans in a state with mandatory Medicaid managed care served remote rural areas. Other plans expanded into areas that offered the most opportunities for increased enrollment, which were generally urban areas.

Plans built or strengthened their provider networks to expand Medicaid service by:

- ***Contracting with providers already located in the expansion areas,*** rather than hiring or attracting new providers into those areas. However, the few mixed-model plans occasionally helped recruit physicians or opened new centers in particular underserved communities. Two of these plans did this to foster and maintain good relationships with the provider groups that participated in the expansions and to seize the opportunity to increase enrollment through the new providers.

- ***Making providers who had not been serving Medicaid available.*** Commercial-based plans often contracted with many providers who had not previously accepted Medicaid patients (commercial-based plans have a Medicaid enrollment that comprises less than 75 percent of total enrollment). These plans were able to interest "new" providers in Medicaid partly by paying higher rates than Medicaid fee-for-service and by accommodating provider concerns about being "flooded" with Medicaid enrollees. Broader market factors such as shrinking alternative sources of income for these physicians also played a role in motivating them to contract with Medicaid-serving plans.

- ***Relying upon FQHCs to a greater or lesser extent.*** Nearly all plans contracted with FQHCs, but the number of such contracts and the extent to which plans relied on FQHCs as key providers in their areas varied widely. Commercial-based plans contracted less often with or relied less on FQHCs, largely because the FQHCs were not interested in doing so (for example, some were committed exclusively to an

FQHC-owned plan) or because plans perceived that the FQHCs are inefficient and the contracting process, cumbersome.

Most plans had established access standards related to (1) a maximum number of enrollees per primary care provider, (2) appointment availability, and (3) 24-hour coverage for their contracted providers. State Medicaid programs commonly required the first two types of standards. However, in monitoring compliance with these standards, plans focused most on the 24-hour coverage, because they viewed this as key to minimizing unnecessary emergency room use and thus lowering costs after office hours. Plans established a standard for some maximum number of enrollees per primary care provider because of state Medicaid program requirements, but they primarily identified access problems through patient complaints rather than by monitoring providers' compliance with this or other standards.

In addition to establishing standards plans typically provided some direct services to support access, known as enabling services, such as case management or transportation. Plans whose core mission was to serve the Medicaid population, and who relied heavily on traditional Medicaid-serving providers to provide this service had provided more extensive enabling services relative to most commercial-based plans. Also, the mixed-model plans provided more enabling services for their staff-model enrollees than for their network-model enrollees. Possible reasons for the difference may include stronger financial incentives to provide cost-effective enabling services for staff-model enrollees, and/or the fact that it is easier (or less costly)for these plans to use their own space to provide some services to enrollees within the tight core area served by their staff-model.

EFFECT OF HEALTH PLAN STRATEGIES AND MEDICAID MANAGED CARE ON CHCs AND OTHER TRADITIONAL MEDICAID-SERVING PROVIDERS

Nearly all of the 19 health centers we visited were involved in Medicaid managed care, and many were heavily involved: 8 had more than 30 percent of their users in managed care plans, 8 were in areas in which Medicaid managed care enrollment was mandatory, and all but 1 contracted with at least one health plan.

Most have broken even or generated a surplus on their Medicaid business, to date. The ones that have done well represent all sizes, contracting strategies, and levels of managed care enrollment. Several factors have been key to their more positive experiences:

- Strong payment rates under managed care arrangements have in some cases been even better than cost-based reimbursement.
- Cost-based reconciliation has provided some health centers with "wrap-around" payments to subsidize below-cost managed care payments.
- Operational and administrative improvements have lowered costs and made health centers more efficient.

These health centers will face greater challenges in the future, however, if, as many observers suspect, cost-based payment or wrap-around financial protections are reduced or eliminated, and capitation payments decline. Also, several of these health centers will be more vulnerable in the future because they have drawn on reserves and/or grant funding to cover managed care losses.

Four health centers have not fared so well. Two lost substantial numbers of Medicaid patients because of managed care, and the other two were losing money under managed care and lacked the reserves and management/administrative systems to cope with such losses much longer before having to make cuts. To date, none of the health centers has had to reduce its scope of services, but two reduced staff and one eliminated on-site pharmacy services. One of the health centers has managed to cope thus far with large declines in Medicaid revenue because many of its physicians donate their time or have agreed to work for substantially lower salaries.

Health departments as a group have had greater difficulty sustaining their primary care operations under Medicaid managed care. Three of the four we visited lost a substantial amount of money as well as Medicaid patients. Two decided to transfer their primary care practices to other providers, and the third was struggling to maintain its clinics amidst increased competition for Medicaid patients and a near-bankrupt county government. The two transfers may actually improve access, however, because under the new arrangements, services will be more comprehensive (one of the health departments had been focusing mostly on children and the other, on adults). Both of these health departments looked positively upon the shift of primary care to other community providers, recognizing that their strengths rested in other areas (in enabling services and in traditional public health functions).

In response to more competition and managed care demands, most health centers were improving their operations and/or administrative systems in ways that should also enhance access. More common changes included expanding the number of sites and/or operating hours, establishing or improving after-hours coverage, adding or designating staff to handle managed care coordination, upgrading their management information system, and improving customer service/customer relations.

EFFECT OF HEALTH PLAN STRATEGIES AND MEDICAID MANAGED CARE ON AVAILABILITY OF PRIMARY CARE SERVICES

Medicaid managed care has thus far had an overall positive effect on the availability of primary care services for Medicaid enrollees. There were no reported negative effects on access for the uninsured, and some of the benefits that accrued to the Medicaid population--including increased number of safety net provider sites and extended hours of operation--also benefitted the uninsured who use the safety net providers.

- ***Direct Effect on Provider Supply.*** Commercial-based health plans and Medicaid managed care programs more generally have been important in increasing the supply of primary care physicians available to Medicaid beneficiaries. However, some plans and providers were significantly concerned that the newly available physicians might not be providing care in a culturally competent way, or that they might turn away from serving the Medicaid population in the future. Neither we nor those we interviewed have enough information about the extent to which these problems occur.

Health plans typically contracted with providers already located in underserved areas rather than recruiting new providers to those areas. Therefore, we did not observe a change in the number of primary care providers practicing in the study communities that could be attributed to Medicaid managed care plan strategies for providing access. Further, the many existing providers that newly opened their practices to Medicaid typically did not open their practices to the uninsured, we were told. Consequently, Medicaid managed care did not make new providers available to the uninsured as it did to the Medicaid population.

- ***Changes in Service Capacity and Patient Volume for Safety Net Providers.*** *The* changes brought about by managed care--including financial changes and increased competition--did not diminish service capacity or patient volume for most safety net providers. In fact, competition prompted some of the providers to increase the number of sites and/or hours of operation, hoping to attract more Medicaid enrollees. Only in the areas with the fiercest competition and where the safety net provider was ill-positioned to compete did we find substantial drops in the number of Medicaid enrollees using the safety net providers.

- ***Changes in the Availability of Enabling Services.*** Managed care has increased the overall availability of enabling services for Medicaid enrollees in the communities we visited, because health plans were providing some enabling services and safety net providers did not discontinue or reduce their level of effort for such services. More specifically, the availability of 24-hour nurse advice lines and after-hours care may be the most substantial direct-service contributions made by health plans to access for Medicaid enrollees. The availability of enabling services remained the same for the uninsured and other community residents.

- ***Changes in Enrollees' Understanding of How to Access Care.*** Many providers and plan staff agreed that the rules of Medicaid managed care made it more challenging for enrollees to know how to access care, especially during the months of transition to a mandatory Medicaid managed care program.

CHANGES UNDERWAY THAT MAY AFFECT ACCESS IN THE FUTURE

It is unfortunate that we cannot assume that these relatively positive findings will hold in the future. Current changes in Medicaid managed care and in the market suggest that access to primary care in the future may become worse relative to what we have observed to date. The following major changes in state Medicaid programs have the potential to affect access differently in the future:

- ***Decreases to Capitation Rates.*** If rumored decreases in capitation rates to plans become a reality, plans warned that access could be diminished by fewer health plan choices as plans leave the Medicaid market, by reduced enabling services from plans, or by reduced provider availability as the providers who have recently begun to serve Medicaid withdraw under pressure of lower rates.

- ***More Competitive Contracting.*** In 6 of 10 markets, a more competitive contracting process was being implemented along with a mandatory managed care program. In these markets, health plan options for beneficiaries were likely to continue to increase. However, respondents expressed greater concerns about future access in three markets where options may decrease as a result of more competitive contracting, though not all those we interviewed agreed on just what this effect on access would be. Regardless of the number of plans that might participate in the contracting process, increased competition may drive down capitation rates and lead health plans to more selectively contract with providers.

- ***Enrollment of the Disabled SSI/Medicaid Population into Managed Care.*** Plans and providers we visited expressed a host of access and payment-related concerns about enrolling the disabled SSI/Medicaid population in managed care.

- ***Reduced Financial Protections for FQHCs.*** Providers were concerned about whether states would continue the current level of financial protections for FQHCs, and if not, whether FQHCs could continue the current level of service.

POLICY IMPLICATIONS

Policies to Date Have Increased the Availability of Primary Care Services for Medicaid Beneficiaries, but How Solid and Durable Is This Increase?

Policymakers have been concerned that the shift to managed care would negatively affect access for Medicaid beneficiaries, the uninsured population, and other vulnerable populations. Though they must be interpreted with caution, our findings offer some reassurance to policymakers that managed care has thus far created many benefits and few drawbacks in access for the Medicaid population.

The positive findings must be interpreted in the context of active state and federal policies that supported access during transition to managed care. There were widespread state policies and efforts related to safety net providers, including strong incentives for plans to contract with them, financial subsidies provided directly or passed through to safety net provider plans, and support for FQHC-based health plans. Our sample of safety net providers in states without these types of policies was too small to assess whether or the extent to which our findings would have been different absent these policies.

Our positive findings should also be interpreted in light of the multiple state requirements for health plans on access. The two most common are a maximum number of enrollees per primary care provider and standards for appointment availability. Although, in design or implementation, the standards appeared to be far from ideal as access measures, they helped to clearly communicate the state's expectation of reasonable access under the plans, and as a result providers and plans alike were operating with this in mind. States also have some leverage through the standards to address problems that might arise, for example, under the scenarios for the future discussed below.

Concerns for the Future Are Significant and Need to Be Monitored

Plans' and providers' concerns about the changes underway in state Medicaid programs strongly suggest a need to monitor changes in access, or at least changes that could signal access problems. In particular, there is significant potential for the following to occur and decrease access:

- ***Reduced Plan and Provider Participation. The*** current high level of plan and provider participation in Medicaid managed care may diminish if capitation rates are reduced as expected and if more competitive managed care contracting processes are initiated as planned. State or national tracking systems for monitoring such changes and reasons for them are not now in place.

- ***Reduced Levels of Service to the Uninsured.*** Continued increases in competition among providers, decreases in capitation rates, and health plans' hopes of transferring more risk to contracted providers all suggest that FQHCs will face greater challenges in the future and may not be able to sustain the same level of services to the uninsured and insured populations. Monitoring the patient volume, services, and financial status of FQHCs could identify warning signals such as the movement of insured patients away from these providers, which could lead to cuts in service. The extent to which FQHCs take on additional financial risk from health plans--and under what conditions they do--is another important issue to track. If the FQHCs assume much additional risk before they have adequate information systems for monitoring, they might have financial problems and feel pressure to reduce services. Conversely, if they accept risk once such systems are in place, this would suggest they are successfully adapting to the demands of managed care.

- ***Cutbacks in Enabling Services by Plans and Providers.*** Health plans and providers told us that the enabling services now in place are quite vulnerable to additional financial cutbacks. Nearly all health plans had one or more services such as transportation or case management beyond the required level in place, but said they would likely cut back on these services in response to much additional financial pressure. Similarly, providers have not yet discontinued enabling services at the local level, despite reduced financial support for them, but they told us they may need to cut back on outreach or other enabling services if financial pressures increase further.

Public-Sector Support to Safety Net Providers Should Continue If They Are to Pursue Their Mission in a More Difficult Future

Given the likelihood of a more difficult future, CHCs and other FQHCs will need sustained financial support from the public sector if they are to continue their present level of service to their communities, though our study does not allow us to assess what forms of support are most appropriate or effective. One possibility is that public financial support, at the same time that it allows an adjustment period to managed care and supports continued service to the uninsured, could be structured to encourage FQHC networking strategies. Plans and some safety net providers viewed these strategies as giving FQHCs the potential to compete better with other organized provider

groups and to take on additional financial risk as markets move in that direction. This view assumes that the strategies would involve real cooperation in areas such as information systems and joint contracting.

Hard Evidence for the Cost-Effectiveness of Enabling Services Would Better Protect Them from Cutbacks

Plans and safety net providers said enabling services would be vulnerable to financial cutbacks in the future primarily because of a lack of hard evidence on their effectiveness and cost-effectiveness. If formal evaluations of specific types of programs, such as case management or outreach, revealed cost-effective models, both safety net providers and plans would be better able to justify retaining them as financial pressures increase.

Consumer Perspectives and Issues Need to Be Addressed

The fact that plans and providers often agreed that some Medicaid enrollees were confused about how to access care under managed care, especially during the transition to Medicaid managed care, suggests that work should continue to refine information provided to enrollees at the time of enrollment. The best choice as to who would perform this work will depend upon how each state has structured its enrollment process.

Finally, further research addressing the effects of different plan strategies on access from the beneficiary's perspective would nicely complement our findings, which reflect provider and health plan perspectives. Surveys could be used, for example, to better assess whether the uninsured population is, in fact, having greater difficulty obtaining timely appointments or being shuffled from one provider to another in the more competitive markets. HEDIS measures for the Medicaid population or information on plans and providers given to enrollees at the time of enrollment could also be used to gain additional insight into the effect of plans' strategies on access to care.

CONCLUSION

Medicaid managed care has thus far had an overall positive effect on the availability of primary care services to Medicaid enrollees and other low-income residents in our study communities. Most community health centers and other safety net providers are actively participating in and faring reasonably well under Medicaid managed care.

But if competition for Medicaid patients increases and Medicaid payment rates decline as expected, many providers fear that they will need to cut back on enabling services and uncompensated care. Some provider organizations are especially vulnerable to change, either because they have already lost a substantial numbers of paying patients or because they are trying to cope with declining Medicaid revenues and expanded managed care without adequate management systems and/or financial reserves. Thus, monitoring for changes in access, or at least changes that would signal access problems, is essential to ensure that policy and market changes do

not undermine access for Medicaid beneficiaries and other residents of underseved communities in the future.

I. INTRODUCTION AND METHODS

A. RATIONALE FOR ASSESSING HOW HEALTH PLAN ACCESS STRATEGIES INFLUENCE ACCESS AND PROVIDER SUPPLY

Expansions of Medicaid insurance coverage over the past decade have improved **financial** coverage and access to care for low-income populations. However, there is lingering concern that the Medicaid population--or at least a significant proportion of the Medicaid population--still faces substantial barriers to access, and thus fails to receive timely and appropriate care. The barriers to access are described by the Institute of Medicine (1993) as being structural, financial, and personal:

- ***Structural barriers*** include a lack of provider availability, care sites that may not be organized to facilitate access, and a lack of transportation to the care site.
- ***Financial barriers*** include a lack of or limitations in insurance coverage; payments to providers that are historically low relative to other payers, thus discouraging providers from accepting Medicaid patients; and a potential shortfall in public support to fill the gaps in care.
- ***Personal barriers*** include language barriers; attitudes toward health care that. may work against appropriate use; cultural barriers; and other factors related to education, income, or acceptability of a person.

Research suggests that to some extent, each type of barrier continues to exist. The Kaiser Commission on the Future of Medicaid (1992), for example, pointed to some remaining financial and structural barriers as key issues in the future of Medicaid. The commission focused especially on the limited participation of physicians in Medicaid, the reliance of many program beneficiaries on clinics and emergency rooms for care, and the lack of coordination in and accountability for services provided under a fee-for-service system. The Physician Payment Review Commission (PPRC) (1994) p**rovides an overview of studies showing that** problems in provider availability exist

in inner-city and rural areas and are linked to lower health status or unfavorable service use patterns. Research conducted by Mathematica Policy Research, Inc. (MPR) has also documented the problems that continue to plague inner-city and rural areas. Issues of access for low-income populations even when covered by Medicaid are highlighted in a recent MPR case study of TennCare (Gold, Frazer, and Schoen 1995). MPR's evaluation of the Rural Health Care Transition Grants Program for the Health Care Financing Administration (HCFA) monitored rural hospitals' difficulties in recruiting providers, and MPR evaluated the Essential Access Community Hospital/Rural Primary Care Hospital Program, which aims to maintain access to care in rural areas that cannot support a full-service hospital (Cheh and Wooldridge 1993, Wright et al. 1995). Examples of studies of problems accessing care in urban areas include MPR's evaluation of a demonstration to improve access to care for pregnant substance abusers and the national evaluation of the Healthy Start Program (Howell et al. 1994a 1994b).

Based on this research, a few of the important barriers to care that appear to remain for many people with low incomes include:

- ***An Insufficient Number of Providers.*** Too few providers may be willing to locate in areas with concentrations of low-income residents and in isolated rural areas. The tendency for physicians to locate in higher-income areas has been well documented (see, for example, Kindig et al. 1987, Fossett et al. 1990) and is evident also in that most areas with health professional and medical facility shortages are either inner-city or rural. In an HMO Primary Care Staffing Study for the Health Resources and Services Administration (HRSA), Felt, Frazer, and Gold (1994) found that HMOs had a difficult time recruiting primary care personnel to work in inner-city and rural areas but not in other areas.

- ***Lack of Transportation.*** Convenient, affordable transportation to care sites with available appointments or sufficient provider capacity may be lacking. For example, HMOs serving Medicaid enrollees that were visited as part of the HMO staffing study emphasized that care sites must be located close to Medicaid recipients' homes and on public transportation routes (Felt, Frazer, and Gold 1994). A few HMOs cited transportation as an unmet need in the areas they serve.

- ***A Variety of Personal Barriers. These*** barriers, and effective methods for overcoming them, are generally not well understood in the field. For example, HMOs visited as part of an MPR evaluation of a quality assurance reform initiative for Medicaid managed care reported consistently lower performance on quality indicators such as immunization rates for their Medicaid patients than for their commercial populations. To explain this discrepancy, the HMOs cited personal barriers to access such as attitudes toward the health care system, in addition to poor health behaviors, the lack of continuous eligibility for Medicaid, and other factors. Though the HMOs studied were attempting to address personal barriers through special services such as outreach and case management, they were searching for more effective ways to address these barriers. PPRC (1994) noted the paucity of studies on personal barriers.

1. How the Growth of Managed Care Relates to Concerns About Access

Supporters of managed care for the Medicaid population often cite improved access to care as a major benefit. As long as individuals stay enrolled, managed care organizations have an incentive to improve the use of both preventive services and early treatment to avoid subsequent costly health problems. Care is often managed by a single primary care provider responsible for the individuals on his or her "panel" of patients; at least in theory, this arrangement should provide better coordinated care than a fee-for-service system in which no provider is responsible for a person's overall care. Felt, Frazer, and Gold (1994) found that HMOs recognize the special needs of the Medicaid population and that most offer nonmedical services, such as outreach, to meet those needs. Further, when HMOs enter an area they influence care patterns there. For example, by seeking to contract with established community providers, they could increase provider case loads and revenues. They could also open a new health center or otherwise recruit new providers enhancing the supply of available providers but potentially competing with traditional community providers.

Skeptics of managed care are less likely to perceive a potential positive influence on access to care. They believe that few HMOs will actually increase the supply of providers convenient to the Medicaid population and that managed care growth may disrupt the parts of the safety net that are

most sensitive to the needs of the Medicaid population, ultimately reducing access by making it more difficult or impossible for traditional Medicaid-serving providers such as community health centers (CHCs) and other federally qualified health centers (FQHCs) to survive. Beyond the overall viability of the CHCs and FQHCs, there is also concern about the effect of managed care on the supply of primary care and specialty providers. The market could force down provider compensation or make practicing in the community otherwise less attractive, thus driving providers away. Or, even if overall provider supply is unaffected, culturally sensitive care may be reduced. Or, managed care could absorb the local provider capacity of an area, leaving less for others such as the uninsured.

The existing studies of these issues are reasonably encouraging on these concerns, suggesting that managed care neither solves nor exacerbates many of these problems. However, current studies provide insights mostly about primary care case management and voluntary managed care programs, which may be less applicable to the current environment (Rowland et al. 1995; Hurley, Freund, and Paul 1993).

2. Why Study of These Issues Is Important Now

The dramatic growth in capitated Medicaid managed care over the past few years, from 2.6 million Medicaid beneficiaries in 1993 to 7.7 million (23 percent) in 1996, is continuing at a rapid pace as states continue to pursue cost savings. Some states are beginning to enroll disabled and elderly Medicaid beneficiaries in managed care. Thus, having a better understanding of the effect **of Medicaid managed care on access is important now** because any effect may be amplified in the future. Further, because the growth in Medicaid managed care has been recent, researchers have never had as much opportunity as now to explore changes in access in vulnerable areas with high growth in Medicaid managed care.

Both national policymakers and local stakeholders need better information on how health plans serving Medicaid affect access and the availability of primary care providers for this population and for inner-city and rural communities more generally. National policymakers need to understand both how provider supply is changing in vulnerable areas and the influence of health plans on these changes to meet their responsibilities related to access and the distribution of providers. Local stakeholders may use the information to assess how the expansion of managed care might affect their community, thus helping them to respond accordingly.

B. PROJECT OBJECTIVES, STUDY QUESTIONS, AND FRAMEWORK FOR ANALYSIS

This study by MPR for the HRSA builds on more general knowledge gained through a previous study to explore the strategies used by health plans to generate access for the Medicaid population and the effects of these strategies. Of special interest for this study is the role that federally funded CHCs and other FQHCs play in helping plans provide access and the effect of managed care on these providers.

Thus, our research questions are:

1. What strategies do health plans use to generate access to primary care for the Medicaid population? What role do traditional Medicaid-serving providers such as CHCs play in these strategies?

2. What are the implications of different strategies for overall access to primary care for the Medicaid population; for the availability of primary care providers; for the availability of culturally competent or minority primary care personnel; for the level of available enabling services; and for the availability of providers specially trained to treat the Medicaid population?

3. How do these strategies affect traditional Medicaid-serving providers in a community CHCs/FQHCs that become part of an HMO network; CHCs/FQHCs that do not become part of an HMO network; and other traditional community providers?

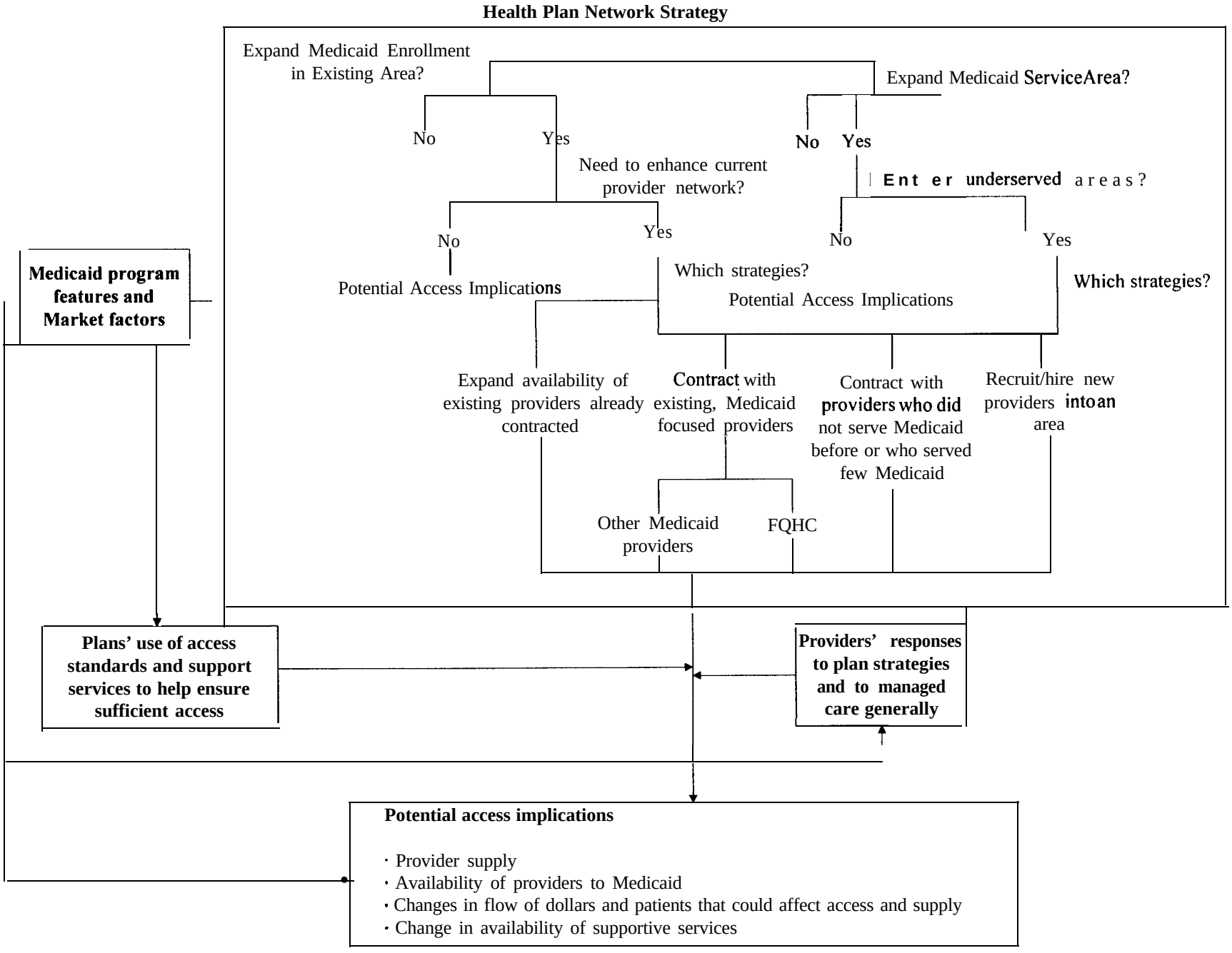
To provide a structure for analysis, Figure I.1 offers a conceptual model of health plan strategies for expanding primary care service to Medicaid. A health plan seeking to expand its enrollment first decides whether to expand its service area or to focus on expansion within its service area. If it is to expand, it must decide where to expand. Since we are primarily concerned about the experience of vulnerable, underserved areas, the decision to enter these areas or not is of interest. A health plan's decision not to enter an area may have access implications for that area. For example, if only one plan is available to Medicaid enrollees in that area, the other plan's decision not to enter the area denies Medicaid enrollees choice and presumably additional access. Our study was not specifically designed to examine where health plans decide to expand and why they choose these areas rather than others, although we present the information we have that bears on these issues.

Once a health plan has decided to expand, it must build a provider network. To do so, it could recruit or hire providers into the area, contract with existing providers already serving Medicaid, or recruit other providers to begin serving Medicaid. If it decides to contract with existing providers already serving Medicaid, it could choose to target or avoid FQHCs. Each of these strategies may have different implications for access. For example, FQHCs in areas where plans avoid FQHCs may find their patient loads and revenues declining as enrollees go elsewhere. This could affect the FQHC's financial status and thus their ability to serve the uninsured. If the plan is expanding by enhancing the provider network within its current service area, it may use any of these strategies and/or expand its capacity by encouraging existing providers to increase the number of enrollees they will accept.

Although the plan's provider network development strategy forms the core of its strategy for providing access to care for Medicaid enrollees, the plan also decides whether and to what extent to

FIGURE I.1

CONCEPTUAL MODEL OF HEALTH PLAN STRATEGIES FOR EXPANDING PRIMARY CARE SERVICE TO MEDICAID AND HOW THEY MAY AFFECT ACCESS



use other tools to help support access. For example, plans may provide enabling services such as outreach, case management, and transportation, to enhance enrollees' use of primary care. They may also use access standards, satisfaction' surveys, and access monitoring to influence providers to provide more access where needed and ensure that access is adequate.

The decisions a plan makes to build its network and to provide enabling services or impose access-related requirements on providers constitute its "strategy" for providing access. An important question for this study, then, is which types of health plans choose which types of strategies? For example, do plans in states with managed care policies protecting FQHCs choose different strategies than other plans? Do commercial-based plans choose different strategies than Medicaid-dominated plans?

In addition to describing the access strategies, the study aims to identify the potential access implications of these strategies. Our conceptual model offers the following types of implications:

- ***Provider Supply. The*** number of primary care providers may change, for example, if a health plan recruits new providers to an underserved area, or if providers leave an area because they are not included in health plan networks.

- ***Availability of Existing Providers.*** More primary care providers may become available if, for example, health plans' rates are higher than Medicaid fee-for-service or if providers view Medicaid more positively due to reduced income from other sources.

- ***Changes in the Flow of Dollars and Patients.*** Because a visible change in access and provider supply could take a long time and be difficult to measure, we are also interested in observing changes like these that could indicate future effects on access. If dollars and patients are shifting away from underserved areas and/or traditional Medicaid-serving providers, the viability of providers in that area may be undermined, raising concerns about access for uninsured and other vulnerable populations, especially if other safety net providers are not available in the area.

- ***Availability of Enabling Services.*** Reduced availability of enabling services could undermine access if, for example, health plans did not pay adequately to support these services by providers, and providers could not make up the difference and thus were

forced to cut needed services, which were not available elsewhere. Enabling services could increase if these services were not reduced at the provider level but were effectively increased by health plans.

- ***Enrollees' Knowledge of How to Access Care.*** If enrollees find health plan rules difficult to understand, or do not seek care from their selected/assigned primary care provider, then their access to care may be diminished.

We are interested in observing these types of changes from the perspective of the Medicaid enrollee, but also identifying changes that may affect the uninsured or other residents of inner-city and rural communities.

C. STUDY DESIGN AND METHODS

The study is primarily based on site visits to 14 health plans and 23 traditional Medicaid-serving providers located in the service areas of the health plans we visited. In addition to interviews, we attempted to quantify changes in primary care provider supply in six locations within our study areas. We chose only six locations because of the exploratory nature of our analysis and our expectation that the available data would be limited. Also, we analyzed data from the Bureau Common Reporting Requirements for the CHCs in our study to provide insights on financial and utilization trends from 1993 through 1995. Appendix A provides more detail on our methodology, which is summarized below.

1. Selection of Participating Organizations

We selected participating organizations using a two-stage, systematic process. First, we selected a health plan, then we selected traditional Medicaid-serving providers from among the inner-city and rural areas that the selected plan serves. This was intended to allow us to explore potential linkages between the health plan's strategy for providing access and its effect on a particular underserved

community. We selected plans and communities that would provide geographic variation, but we also limited the number of states. Since state Medicaid programs are complex, we knew we could better understand the influence of state policies in states where we visited multiple plans. We visited 14 plans in 8 states. Plans and providers were not selected to be statistically representative of a particular group. In selecting health plans, we targeted plans with the following characteristics:

- Service to urban, high-poverty areas and/or rural areas, with at least one CHC in their service area
- High volume of Medicaid enrollees (at least 20,000) and substantial growth in Medicaid enrollment (at least 10,000) between 1993 and 1995.' These plans, we reasoned, should be best able to explain their strategies for making services accessible to the Medicaid population and should be having the most effect on Medicaid access, since large numbers of beneficiaries are enrolled and enrolling in these plans.
- Located in states other than Tennessee or Oregon, because the number of research studies on managed care in those states at the time suggested we would not get good cooperation and might be duplicating the effort of other studies.

In addition, from the information available from the HCFA enrollment reports and the Group Health Association American (GHAA) Industry Directory, we selected plans that together represented diverse characteristics, with some serving rural areas, some all-Medicaid, some heavily commercial, some from national HMO firms, and some from each of several geographic regions and serving different types of areas (e.g., rural versus urban).

We initially targeted 16 plans located in six states. Ten of the 16 targeted plans agreed to participate in our study. Substitutions were made for four of the other six plans, keeping as close to our original criteria as possible, for a total of 14 participating plans. Generally, we were

'One plan that did not quite meet these criteria was included anyway because it was nearby, reducing potential travel cost, and was growing such that now it probably would meet the criteria. A second was included because it was a rural-based HMO.

successful in obtaining cooperation from plans that together generally represent our target characteristics and we were able to visit all except one of the targeted market areas.

An assurance of confidentiality was a key factor in obtaining health plans' cooperation to participate in the study and probably also contributed substantially to the quality and depth of information. Therefore, no plan names are provided, and we have attempted to conceal information that could reveal the identity of a particular plan.

Safety net providers were selected systematically in each plan's service area, using the following rough guidelines:

- Where feasible, we selected one provider in each service area (preferably a CHC) that was under contract with the plan and served a substantial number of plan enrollees, and a second that was not participating in managed care.
- We wanted to include visits to at least a few rural providers; therefore, we seized this opportunity when selecting among options in some areas.
- Where we heard that a safety net provider was discontinuing primary services because of Medicaid managed care in an area served by a study plan, we visited that provider. We viewed understanding discontinuation of services at safety net providers as key to assessing whether access was changing for that community. This occurred twice and both times the provider was a local health department.
- Because of the importance of CHCs to the infrastructure of underserved areas, and the special responsibilities of the HRSA for those facilities, we selected CHCs on a preferred basis in the areas we visited.

In fact, we did not always have much information about the Medicaid-serving providers in an area so, in some areas, our choice of providers could be considered random from among the relevant listings in the Primary Care Programs Directory issued by the Bureau of Primary Health Care at HRSA.

2. Site Visit Approach

Site visits were conducted from April through December 1996. Visits typically consisted of a day and a half of on-site interviews, with a half day spent with health plan executives and two to three hours with each safety net provider's key personnel. We met with the plan executives responsible for building the plan's provider network and for any other plan services related to providing access to primary care for Medicaid enrollees. At the selected safety net providers, we interviewed the administrator and any other personnel with roles relevant to the study topics (often the medical director and chief financial officer).

Semistructured interview protocols were used for health plans and the traditional Medicaid-serving providers. After obtaining an overview of the plan and background on the plan's Medicaid service, the health plan interview protocol covered the following topics, with questions and probes for each: (1) provider network in inner-city and rural areas, (2) gatekeeping and coordination of care policies, (3) the role of CHCs in providing accessible and appropriate care, and (4) special services or steps taken to enhance access. For mixed-model plans, we asked additional questions about the interrelationships of the different components and how the components differed or were similar in terms of the access strategies outlined above. To keep the interviews to a reasonable length, we focused on the fastest-growing component of the mixed model plan, then asked brief summary questions about the other component.

The interview protocol for the traditional Medicaid-serving providers differed depending on whether providers were under contract with the study plan, but covered similar topics: managed care experience, specific information about experience with the study plan (omitted for noncontracted providers), services and staffing, and utilization and financing trends. Also, we obtained Bureau Common Reporting Requirement (BCRR) data when available and a checklist of services provided

in advance of the visit; these data were discussed on site in addition at the time of the interview, except in a few cases where time was limited. The interviews were documented in detail following the visit in a common format to facilitate comparisons across sites.

3. **Analysis**

We analyzed the study information primarily using qualitative analysis techniques, though some descriptive quantitative analysis was used to analyze trends in CHC patient care volume and revenue, and to analyze changes in provider supply in six focus areas. Our approach to analyzing each of the research questions is described in Appendix A, but the following bullets highlight key features of our analytic approach:

- Site visit interviews with the health plans were the primary source for analyzing what strategies health plans use to provide primary care for the Medicaid population and the role of Medicaid-serving providers such as CHCs in these strategies
- Multiple sources of information were synthesized to identify implications of different health plan strategies for access to primary care. Sources included:
  - Self-reports by the health plans on perceived effects of the different components of their strategy for providing access.
  - Specific examples or other evidence (such as a specific decline in the emergency visit rate or another targeted indicator) plans gave of the stated effect.
  - Information from the safety net providers about access-related changes that had occurred at their facilities and in their communities since 1993, and their perceptions of the causes of the changes. The changes we discussed that related to access included the number of Medicaid-serving providers in the community, the number of providers serving the uninsured, in staffing and enabling services available from the visited provider and others, in the remaining access needs in the community, and in the financial situation of the provider.
  - Directories of providers and BCRR data supplemented by telephone calls to providers in six areas with especially high growth in Medicaid managed care. Although our analysis of how health plan access strategies have affected access was mainly qualitative, we attempted to quantify provider supply changes in six areas that we

visited with especially high growth in Medicaid managed care. The attempt proved largely infeasible due to data and response problems discussed in Appendix B.

- Site visit interviews with safety net providers were used together with BCRR data for 1993 and 1995 to analyze the effect of health plan strategies on traditional Medicaid-serving providers.

4. Strengths and Limitations

This study shares the strengths and limitations of all multisite studies that use a case study approach and a nonrandom site selection methodology: a rich depth of information for each site, but no way to know if the sites as a group represent the population of interest. Therefore, we report findings that are obvious based on our analysis, but we do not quantify the extent of difference among the types of plans or providers we visited or the extent of a given effect.

In particular, the following characteristics of our selected sites might have affected our results:

- Only health plans with a high volume of Medicaid enrollees and a high growth in that volume over the past few years were selected. This type of plan might be expected to pay more attention to the needs of Medicaid enrollees and thus be more access-sensitive than plans with a low volume of Medicaid enrollees.

- Older health plans were over-represented in our study; the strategies described here cannot be assumed to hold true for new plans, though the two new plans in the study appeared similar in most behavioral respects to one or more other, older plans in the study.

- Only one rural-based plan and three rural providers were included in the study. Thus, our assessment of how rural and urban experiences differ may not hold true for a broader sample of plans and providers.

- Because we chose CHCs over other types of traditional Medicaid-serving providers in the inner city and had few of each of the other types in our study, we can say more about the experience of CHCs than about these types of providers more generally.

Also, we had to make substitutions for 4 of the 16 originally targeted health plans because they refused to cooperate with the study (most often citing time constraints) or would not return our calls.

The uncooperative plans were generally large organizations where Medicaid represented a small proportion of their total patient population. Though we cannot fully know how this may have affected our results, we were able to substitute other large plans with a small proportion of Medicaid for some of these, and we visited providers in the market areas of the originally targeted plans (except in one case). We feel comfortable we did not miss any large effects on access that these plans may have been having on the visited areas. In addition, our interviews with the two national-level health plan executives reinforced our findings on several key points and did not contradict any other findings. Nevertheless, our findings may not represent the strategies of large commercial-based plans.

Finally, we were not able to get a consistent depth of information on each topic from every site. We have missing information from one or two sites on many of the more specific features of interest. Our findings take this missing information into account by only reporting large differences among plans, providers, and communities. Where observations from one or two sites may raise an interesting question, we are specific about the level of information being used and do not draw conclusions.

D. OVERVIEW OF VISITED SITES

This section provides a brief descriptive overview of the health plans and providers we visited, and of the market and state Medicaid policy context they exist in. Appendix A provides additional descriptive information.

1. Health Plan Characteristics

The study involved interviews with 14 health plans serving Medicaid beneficiaries located in 10 markets (Table I. 1). Largely reflecting a national trend toward managed care arrangements that

TABLE I. 1

CHARACTERISTICS OF HEALTH PLANS STUDIED

	Number of Health Plans
A. Plan Type and Size	
Model	
Network /IPA	11
Group/Staff	0
Mixed Model	3
Tax status	
Nonprofit	7
For-profit	7
Ownership	
National Managed Care Company	0
Regional Managed Care Company	1
Commercial Insurer or Blue Cross Blue Shield	3
Independent and Other	10
Total Enrollment	
< 50,000	4
50-99,999	3
100-249,999	5
250,000 or more	2
B. Medicaid Service	
Years Serving Medicaid in area	
o-1	2
2-4	2
5-9	2
10 or more	8
Medicaid Enrollment	
< 20,000 enrollees	2
21-40,000 enrollees	3
41-65,000 enrollees	4
> 65,000 enrollees	5
Medicaid as a Proportion of Total Enrollment	
< 25 percent	4
25-49 percent	1
50-74 percent	2
75-89 percent	2
90 percent+	5

involve contracting with independent providers, all the study plans were either network/IPA model plans, or mixed-model plans--those with both a network/IPA model component that contracted with independent providers and a group or staff-model component that employed physicians full-time to provide care to enrollees. We found it was these types of plans rather than pure group/staff model plans that met our criteria for high and growing Medicaid enrollment. Even in the mixed-model plans, it was the network/IPA model component of the plan that had most of the recent enrollment growth, and thus was the major focus of our interviews.

Although we selected only plans with a high number of Medicaid enrollees, only half of the plans were Medicaid-dominated, with Medicaid enrollees making up 75 percent or more of total enrollment. Four of the 14 plans were large, commercial-based plans each with more than 170,000 enrollees. Medicaid represented 15 to 2 1 percent of total enrollment for these plans.

Also of note, the plans tended to be experienced in serving Medicaid (only two had begun serving Medicaid in the past year and 8 had served Medicaid for more than a decade), were largely independent rather than owned by a national managed care firm, were about evenly split between for-profit and nonprofit organizations, and were all licensed HMOs at the time of the visit.[2] Several of those we visited are listed in the top 25 Medicaid-serving plans in the nation in terms of the number of Medicaid enrollees they serve; five served more than 65,000 Medicaid enrollees. In contrast, the average Medicaid enrollment for Medicaid-serving plans was 2 1,500 in 1996.

2. Characteristics of Visited CHCs and Other Traditional Medicaid-Serving Providers

The type, size, and history of participation in managed care varied considerably among the providers in the study, as shown in Table 1.2. We visited a total of 23 safety net providers: 13 CHCs,

[2]One had recently been bought by a commercial HMO but had previously operated under a state licensure category for Medicaid-only plans.

TABLE I.2

OVERVIEW OF TRADITIONAL MEDICAID PROVIDERS VISITED

Characteristics	Number of Study Providers: Community-Based Health Centers N=19	Number of Study Providers: Health Departments N=4
Type of Provider		
CHC	13	0
Other FQHC	4	1
Other (rural health clinic, municipal clinic, non-FQHC health departments)	2	3
Service Area		
Large Urban	11	3
Small Urban	5	1
Rural	3	0
User Volume		
Under 5,000	3	2
5,000 to 10,000	4	0
10,000 to 20,000	4	1
More than 20,000	7	1
unknown	1	0
Proportion of 1995 Revenue from Medicaid		
Under 30 percent	3	1
30-50 percent	10	2
More than 50 percent	5	0
unknown	1	1
Number of Managed Care Enrollees (1995)		
None	5	1
1-2499	5	1
2500-5,000	4	1
More than 5,000	4	1
unknown	1	0

TABLE *I.2 (continued)*

Characteristics	Number of Study Providers: Community-Based Health Centers N=19	Number of Study Providers: Health Departments N=4
Proportion of Users in Medicaid Managed Care		
Less than 1 percent	3	2
1-9 percent	0	0
1 O-3 5 percent	6	0
More than 3.5 percent	5	0
unknown	5	2
Relationship with FQHC Plans or Networks		
Affiliated with an FQHC plan	6	1
Part of an FQHC network	4	0
No involvement	9	3
Enrollment in Medicaid Managed Care to Date		
Voluntary	11	2
Mandatory	8	2
FQHC Cost-related Reimbursement under Managed Care to Date		
Available	8	1
Not available	11	3

3 FQHCs, four health departments, a rural health clinic, a municipal clinic, and a homeless program grantee that is applying to be a CHC.

Medicaid and grants were the main sources of revenue for the providers we visited. Medicaid represented half or more of their revenue for five providers, and the same was true for grants for 10 providers.

The level of managed care involvement varied widely, though all but one were involved to some extent:

- A substantial minority were new to managed care: six had held no contracts in 1995, though all but one had since entered into at least one managed care contract. Most contracts were held individually with health plans rather than through an IPA or other larger provider group.
- In about half the providers, managed care enrollees comprised 10 percent or more of their patients, with five providers having more than 40 percent of their patients in managed care.
- The providers' managed care contracts generally involved capitation for primary care only. Less than half the providers held contracts that involved some sharing of savings tied to specialty and hospital utilization.

For a slight majority of the health centers, enrollment in Medicaid managed care was still voluntary at the time of the visits, although programs in all but one of these markets were expected to convert to mandatory enrollment in 1997. Cost-based reimbursement was still available either through enhanced managed care payments or wraparound reconciliation from the state for FQHCs in half of the study markets, although in at least two of these five markets FQHC reimbursement protections were expected to end or to be scaled back when Medicaid managed care becomes mandatory.

3. Market Area and Medicaid Program Characteristics

As explained earlier in this chapter, the health plans we selected determined the geographic areas in the study. Thus, there are two geographically defined sets of "market areas" that are relevant for the study: (1) the health plans' service areas, in full for the smaller plans or specific to a metropolitan area or substate region of high Medicaid growth for the large plans, and (2) the communities served by the traditional Medicaid-serving providers we visited within the health plan service areas. The communities served by the traditional Medicaid-serving providers we visited are far smaller than the plan service areas, and data are not available on them to summarize in a table. Generally, they are in the poorest, most troubled neighborhoods within the plan's service area.

Characteristics of the health plan service areas or the subset of a service area that we focused on are summarized here and presented more fully in Appendix A. Because of overlaps among health plan service areas, there were 10 geographically distinct markets for the 14 plans. Important characteristics of the markets include:

- ***Geographically dispersed locations.*** Northeast, Midwest, and Western regions were represented in the study which included markets in California, Colorado, Connecticut, Michigan, New York, Ohio, Pennsylvania, and Washington State. In the South, most plans that met our criteria were in a single state. (Several plans in that state refused to participate in the study, citing time constraints or not answering our calls.)

- ***Relatively High Managed Care Penetration.*** HMO penetration in the commercial segments of the markets visited was considerably higher than the national rate, probably reflecting the tendency for Medicaid managed care to expand most rapidly in areas with a commercial managed care base.

- ***Higher rates of Medicaid coverage and lower rates of uninsured than the nation as a whole.*** We do not know if this is related to the geographic location generally (e.g., if coverage is lower in the South, influencing national figures), or if it is related to where states have placed a priority on expanding managed care (e.g., if the costs are higher for higher coverage, the state may more urgently need to cut costs through managed care). None of the areas we visited 'were in states that had expanded their coverage for Medicaid during the study period.

- ***State Medicaid managed care programs that were almost all either mandatory programs, or voluntary programs shifting to mandatory in the near future (five*** and four markets, respectively). Only one was voluntary and likely to remain voluntary (the core service area of the rural-based plan we visited).

- ***FQHC provider protections that varied from none, to enhanced payment, to incentives in the contracting process encouraging plans to contract with FQHCs.*** Four markets were located in states that provided cost-based enhanced payment to FQHCs and CHCs for services delivered to Medicaid beneficiaries. Two states specified that such payments be made through Medicaid managed care plans, while the other two states provided these enhancements to the FQHCs directly through a traditional cost-based reconciliation process.

- ***Other Medicaid managed care program features that varied,*** including whether the state was "carving out" mental health services in its managed care program, whether it had a specific certification process to qualify providers to serve Medicaid, and the types of access-related requirements it placed on health plans. Several areas included the SSI population in managed care on a voluntary basis, and several were planning to include this population in mandatory programs in the future (this change was imminent in only one area we visited).

E. ORGANIZATION OF THIS REPORT

The next chapter of this report describes health plans' strategies for providing access to primary care for Medicaid enrollees. Chapter III describes how safety net providers are responding to Medicaid managed care, and Chapter IV draws on information presented in Chapters II and III to present our analysis of how health plan strategies--and Medicaid managed care more generally--appear to be affecting access to primary care for Medicaid enrollees and for other residents of inner-city and rural communities. Chapter V summarizes our conclusions and the policy implications of our findings.

II. HEALTH PLAN STRATEGIES FOR PROVIDING PRIMARY CARE FOR MEDICAID ENROLLEES

Health plans that decide to expand service to Medicaid face a series of decisions that together constitute their strategy for providing access to primary care for the Medicaid population. They must first consider if they should expand their service area, and if so, where should they expand it--and to what extent should they enter underserved areas? How should they reinforce or expand their primary care provider network? The possibilities include some combination of the following:

- Recruiting/hiring new providers into an area
- Expanding the availability to Medicaid patients of providers that already serve plan enrollees
- Contracting with providers that did not serve Medicaid before or served few Medicaid patients
- Contracting with existing, Medicaid-focused providers such as FQHCs

Finally, the plan must decide whether and how much to use other tools--access standards imposed on providers with or without monitoring, satisfaction surveys, and enabling services--to help enhance access.

Overall, we found plans were expanding their service areas aggressively and were including urban underserved areas in their expansions. Medicaid-dominated and commercial-based plans differed in their strategies for providing access for Medicaid enrollees. Generally, plans that were Medicaid-dominated and had originated with Medicaid service as a core mission relied more on traditional Medicaid-serving providers, and provided more numerous and more extensive enabling services to help enhance access for Medicaid enrollees relative to other plans. In contrast, commercial-based plans made providers available to the Medicaid population who had not

previously served Medicaid. State Medicaid program requirements appeared to influence the number of standards and services in place to support access. However, many supportive efforts far exceeded state requirements. Also many standards were in place on paper (e.g., to meet state requirements), but were not monitored or enforced.

A. ENTRY INTO THE MEDICAID MARKET IN UNDERSERVED AREAS

Key Findings

- *Health plans aggressively expanded their service areas during 1993-1996 and included underserved urban areas in their expansions.*
- *Expanding into rural areas was not a priority for the plans, since rural areas did not offer as much opportunity for increased enrollment.*

Health plans expanded aggressively from 1993 through 1996. The 14 health plans we studied collectively increased the number of Medicaid enrollees they served by more than 275,000 during this time frame, both by increasing their Medicaid enrollment within their 1993 service area and by expanding their Medicaid service areas. All but two plans' service areas expanded during this period, and half of those plans expanded into three or more additional counties. The two health plans formed since 1993, both in response to state Medicaid managed care initiatives, now serve enrollees in 8 and 16 counties, respectively.

Health plans in the study did not avoid expanding into underserved urban areas.' In fact, most of the counties that the study plans expanded into included federally designated primary care health

'Our interview protocol was not specifically designed to examine why plans expanded or did not expand in the places they did, except to ask if provider supply restricted their expansion (it did not), but we report here relevant information from our interviews.

professional shortage areas (HPSAs).[2] However, including underserved areas was more a natural result of expansion to increase Medicaid enrollees than a conscious decision to expand into this type of area. And we could not tell whether or how well plans covered the most poverty-stricken neighborhoods within a city, since they described their service areas in relatively large geographic terms, such as by county or major part of a county.

We learned the following about how and why the plans we visited were expanding their service areas:

- The plans that expanded the most did so in anticipation of or simultaneous with state moves to mandatory managed care for Medicaid beneficiaries (five plans). To maximize their potential enrollment, plans expanded to include areas (usually urban) where a shift to mandatory managed care was imminent and other areas with larger numbers of potential enrollees.

- Plans that contracted with larger medical groups and IPAs tended to be opportunistic, seeking to contract with these groups in areas where they found them, usually urban areas though some included rural providers as well (three plans).

- To some extent, expansion tended to radiate geographically from the plan's current service area, incorporating more suburban areas or other parts of major cities, and/or encompassing other cities, towns and rural areas, depending on the plan's original service area, the states' plans to move to mandatory managed care for Medicaid, and the aggressiveness of the planned expansion (Table II. 1).

- In most instances, network development staff in the health plans initiated the expansions by contacting prospective medical groups, IPAs, or other providers, though in one case the hospitals that served as core providers for a plan aggressively expanded out into additional geographic areas, buying physician practices and thus expanding the plan's network.

'A rough count for 11 of the 14 plans indicates 63 of 77 counties were designated primary care HPSAs, either part-county or whole county, designated by geographic area, facilities, or populations.

TABLE II. 1

CHARACTERISTICS OF CASE STUDY PLANS' EXPANSIONS 1993-1996

	All Plans (of 14)	Plans Focused on Traditional Medicaid-Serving Providers (of 6)	Other Plans (of 8)
Character of Core Service Area			
Large city	12	6	6
Smaller city	5	1	4
Small towns/rural	1	0	1
Serves any rural areas	8	3	5
Number of Additional Counties by 1996			
0	2"	2	0
1-3	2	1	1
4-9	5	2	3
10 or More	3	0	3
Not applicable[b]	2	1	1
Increase in Medicaid Enrollment			
o-9,999	1	0	1
10-19,1999	1	0	2
20,000 or More	10	4	4
Not applicable[b]	2	1	1
Character of Additional Counties[a]			
Large city	9	3	6
Smaller city	7	2	5
Small towns/rural	7	2	5
Not applicable[b]	3	2	1
HPSA-Designated Counties Included in Expansion[b]			
Yes	9	2	7
No	1	1	0
No expansion of counties	2	2	0
Not applicable[b]	2	1	1

'One of these plans expanded within the large county that comprised its service area.

[b]Two plans where organizational changes were profound and comparison with 1993 data did not make sense and/or the plans service area did not expand.

. Expanding into rural areas was not a priority for most urban-based plans, because rural areas offered less opportunity for increased enrollment. However, the plans located in a fairly rural state that had moved to mandatory managed care statewide were contracting in rural areas as part of their expansion. Only one plan, a commercial-based plan expanding rapidly into markets in other states, specifically noted that it does not enter truly underserved areas such as remote rural areas, preferring areas with the potential for sufficient provider networks.

Reports from the FQHCs and other safety net providers we visited suggest that the entry of the plans in our study, which as a group were relatively Medicaid-focused, into underserved urban areas roughly mirrored the behavior of other plans. That is, the providers reported that many plans had been entering their market areas in the past few years, ranging widely from commercial plans that had not served Medicaid in the past to plans that had long served Medicaid in other areas and to plans that they had helped form.

B. HOW PLANS BUILD OR STRENGTHEN THEIR PROVIDER NETWORKS TO EXPAND MEDICAID SERVICE

Key Findings

To build or strengthen their provider networks to expand Medicaid service, plans:

- ***Contracted with providers already located in the expansion areas** rather than hiring or attracting new providers into those areas. However, several study plans (especially the mixed-model plans) helped recruit physicians to particular underserved communities.*
- ***Made providers available to Medicaid that had not served Medicaid before.** Commercial-based plans frequently contracted with providers new to Medicaid service. Plans were able to interest these providers in Medicaid in part by paying rates higher than Medicaid fee-for-service rates and accommodating specific provider concerns about being "flooded" with Medicaid enrollees. Broader market factors, such as shrinking alternative sources of income for these physicians, also played a role.*

Key Findings (continued...)

- ***Varied in how much they relied on FQHCs.*** *Nearly all plans contracted with FQHCs, but the number of such contracts and plans' reliance on FQHCs as key providers in their areas varied widely. Commercial-based plans less often contracted with or relied heavily on FQHCs, largely due to lack of interest to date by the providers or plans' concerns about efficiency or the contracting process.*

Faced with a need to strengthen or form a provider network to accommodate expansion, health plans use a combination of strategies that may have different implications for low-income individuals' access to care.

1. Overview of Selectivity and Contracting Preferences

At the time of our visits, plans were generally not selective in contracting for primary care, beyond requiring that providers meet credentialing standards. However, some plans did express preferences for certain types of providers (Table 11.2). Plans that expressed preferences most often preferred providers with a high volume of Medicaid enrollees and/or hospital groups. High-volume Medicaid providers offer plans the most potential to significantly increase their Medicaid enrollment. Hospital groups are preferred either because of links between the plan and a particular hospital system and/or because such groups may be able to take on more financial risk than other providers. Despite having preferences for certain types of providers, most plans' primary care contracting strategies were inclusive except that:

- Several plans avoided contracting with one or more specific medical groups or places that had strong affiliations with competing plans.
- One plan required, and three others strongly preferred, that contracting providers be able to accept their full-risk payment strategy.

TABLE II.2

OVERVIEW OF HEALTH PLANS' STRATEGIES FOR BUILDING OR ENHANCING PRIMARY CARE NETWORKS

	All Plans (of 14)	Plans Focused on Traditional Medicaid-Serving Providers (of 6)	Other Plans (of 8)
Influence on Recruitment of New Providers to One or More Communities			
Yes	4		2
No	10		6
Contracted With Additional Primary Care Providers to a Large Extent			
Yes	13		8
NO	1		0
Provider Characteristics Targeted in Contracting"			
High-volume medicaid providers or traditional medicaid-serving providers	7	6	1
Patient mix includes many commercially insured patients	3	0	3
Ethnic, bilingual providers in certain areas	3	1	2
Hospital-based groups	7	4	3
No targeting, any that will take plan's payment	8	2	6

"Many plans targeted more than one of the groups listed and so are counted more than once.

- One plan, which is focused on Medicaid service and primarily uses full-risk contracting with groups/IPAs, only contracts with new groups/IPAs that show their physicians are interested in serving Medicaid enrollees.

2. Infrequent Use of Strategies to Bring New Providers into Underserved Communities

The health plans in the study generally contracted with providers already located in inner-city and rural areas rather than hiring or attracting new providers into those areas. This is consistent with the national trend toward managed care plans based on provider networks that do not directly hire or employ physicians.

A few plans--including two of the three mixed-model plans--occasionally helped recruit physicians to underserved communities. For example, one of the three plans in the study with a staff-model component had hired additional physicians for three new inner-city locations.[3] This was an important part of its strategy for accommodating expanded enrollment, though it also contracted with many additional network providers. This plan originated as a staff model and views its Medicaid-focused health centers as the best way to serve Medicaid, because the centers create a comfortable, almost "social" environment, are designed for mothers and children, and have dedicated staffs sensitive to the needs of the population. Four other plans reported assisting contracted providers in recruiting in areas with acute supply problems:

- One plan helped stabilize a rural hospital (through financial assistance) that employed the two primary care physicians in that town. Once stable, the hospital was able to hire a third primary care physician. The same plan recently donated $50,000 toward renovation of a hospital in another small town that employs physicians and donated $150,000 to the career center of another rural hospital.

[3]One of the other mixed-model plans had also expanded its staff model component, adding three new centers during 1993-1994, but the new centers were neither related to expanded Medicaid enrollment nor in underserved parts of the service area.

- A second plan (a mixed-model plan) paid up-front practice overhead costs for primary care physicians willing to relocate to an underserved urban area with many Medicaid enrollees and a chronic shortage of providers. It also used this approach in several other cases in other parts of its service area where existing providers were not willing to join the plan.

- A third plan influenced a contracted medical center to open a new satellite clinic in a rural area to increase its capacity to accept Medicaid enrollees with the plan.

- A fourth plan (another mixed-model plan) had helped to establish a health center in an underserved urban area by guaranteeing to pay doctors' salaries and to buy all the center's equipment if the project failed.

That two of three mixed-model plans in the study had helped in this way may indicate that executives of mixed-model plans responsible for direct service delivery through group or staff-model sites are more inclined to become involved in service delivery issues at the community level than executives of network/IPA model plans.

3. **Expanding Availability of Providers Already in the Network**

Only two plans worked to expand the availability of providers already in their network as part of their effort to attract and serve new enrollees. One plan offers an enhanced capitation payment to providers that satisfy 8 out of 10 access-related requirements, including after-hours care and/or Saturday hours, follow up on no-show patients, and high marks from their enrollees on the plan's satisfaction survey. The other, which pays providers the same rate for Medicaid as for commercial members and reports nearly all its providers accept Medicaid, offers a bonus to providers who increase the number of plan enrollees. The relative scarcity of strategies for increasing the availability of providers already contracted with the plan may reflect plans' arms-length approach to trying to influence which and how many enrollees providers care for.

4. Contracting with Existing Providers Who Previously Had Not Served Medicaid

Commercial-based plans frequently contracted for Medicaid services with providers that had not previously served Medicaid. Other plans did so to a lesser extent. A combination of incentives and accommodations reportedly persuaded these providers to begin serving Medicaid, although broader market factors--such as shrinking alternative sources of income for these providers and fear of the future--also played a role.

A major incentive to providers was plan payment for Medicaid managed care enrollees that was higher than Medicaid fee-for-service rates (specifically mentioned by three of seven plans with substantial commercial enrollment). The two plans that paid providers the same for Medicaid as for other enrollees--and thus strongly encouraged commercial-oriented providers to serve the Medicaid population--were both commercial-based plans that applied all the same polices and offered the same set of providers to Medicaid enrollees as to other enrollees.

Two plans--the two newly formed plans in the study--made specific accommodations to encourage providers to serve their Medicaid enrollees. These included allowing the providers to (1) limit the area from which they would accept new Medicaid enrollees and (2) set a cap on the number of Medicaid enrollees they would accept from the plan. This relieved the fears of some providers that they would be flooded with new Medicaid enrollees.

Generally, we did not find commercial-based plans insisting that contracted providers serve Medicaid as well as commercial enrollees. Of the seven plans with substantial commercial enrollment, only one required providers to serve Medicaid, and it paid providers the same for all enrollees. Most plans, including the one that had this requirement, doubted that such a strategy would effectively increase access. Several plan staff members said the providers would find ways to limit access to appointments by Medicaid enrollees if they did not want to serve them, whether

or not they officially accepted them. Also, this hard-line approach appeared unnecessary, since most primary care providers are now reported to be interested in serving Medicaid.

5. Contracting with Existing Medicaid-Serving Providers

All the study plans contracted with existing Medicaid-serving providers in the new areas they were entering, which most plans viewed as essential to their ability to attract enrollees. However, some types of plans focused less on existing Medicaid-serving providers than others, including: (1) the commercial-based plans that were integrating Medicaid enrollees with their commercial enrollees using a provider network developed for the commercial population, and (2) plans that primarily relied on full-risk contracts with large provider groups and IPAs (four in our study).

6. Role of FQHCs in Provider Networks Varied by Plan Type and Was Influenced by Medicaid Requirements

The extent of plan contracts with FQHCs, the role FQHCs play in serving plan enrollees once under contract, and plans' views of their experience with FQHCs all help explain how plans are providing access to primary care in underserved areas and why they are pursuing the strategies they have chosen.

a. Alternative Strategies for Contracting with FQHCs

Plans varied widely in how much they relied on FQHCs as key providers in their inner-city and rural service areas.[4] Many plans--including most commercial-based plans--contracted with fewer than half the FQHCs in their service area (Table 11.3). Only four of the 14 plans contracted with all

[4]Health plans did not distinguish between FQHCs and CHCs.

TABLE II.3

ROLE OF FQHCs IN PROVIDER NETWORKS AND PAYMENT TO THEM

	All Plans[a] (of 14)	Plans Focused on Traditional Medicaid-Serving Providers (of 6)	Other Plans (of 8)
Extent to Which Plan Contracts With FQHCs			
Not at all	1	1	0
Fewer than half in service area	7	0	7
Half or more than half	2	1	1
All in service area	4	4	0
Role of FQHCs in Serving Plan's Medicaid Enrollees in Their Service Areas			
Substantial	5	4	1
Minor	7	1	6
Mixed (depends on FQHC)	1	0	1
Unknown	1	1	0
Years Plan Has Contracted With One or More FQHCs			
<3	5	1	4
3 or more	8	4	4
Unknown	1	1	0
Payments to FQHCs Relative to Others			
Same as to other primary care providers	5	3	2
Different from other primary care providers	6	2	4
Unknown	3	1	2
Payment Method to FQHCs			
Not capitated	1	0	1
Primary care capitation	9	4	5
Primary and specialty care capitation	1	1	0
Full capitation	0	0	0
Unknown	3	1	2
Indirect Contracting			
Direct with FQHCs	11	5	6
Indirect through group/IPAs	2	0	2
Unknown	1	1	0

[a]Many plans targeted more than one of the groups listed and so are counted more than once.

the FQHCs in their service area. These four plans were all Medicaid-focused with provider networks drawn from traditional Medicaid-serving providers.[5]

The plans that did not rely heavily on FQHCs in the underserved parts of the service areas typically used an array of other providers experienced with Medicaid. The other available providers included hospital outpatient clinics (not always collocated with the hospital), religious-affiliated clinics, and individuals and small groups, depending on the market. For example, one plan had been formed through the local medical society by independent (not FQHC-affiliated), largely minority physicians focused on Medicaid service. In another instance, the plan was owned by a religious organization, and its affiliated health system included many clinics in the city that served low-income populations.

Also, plans may officially serve some neighborhoods in their service area but fail to contract with the only convenient provider. For example, one plan's service area includes an entire city. Within the city, we visited a FQHC that is the key provider for a small, largely Hispanic neighborhood. The FQHC was not under contract with the plan and other plan providers, though geographically close, were not easily accessible via public transportation from that area. Thus, the plan covered the area, but not very well. (Medicaid beneficiaries in the area tended to select alternative plans that would allow them to continue with the more convenient FQHC.)

b. Role of FQHCs in Serving Plan Enrollees, and Plans' Views on their Experience

Having FQHC contracts in place does not guarantee these providers will play an important role in serving plan enrollees within the FQHCs' service areas. Similar to the pattern for contracting,

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'Three of the six plans we characterized as being focused on traditional Medicaid-serving providers actually originated from Community Health Centers and over time developed large provider networks. Of the other three, one originated from a public hospital, one was formed by independent minority physicians in the inner city, and one was started by an out-of-state company in response to the state's plans to increase Medicaid managed care.

Medicaid-focused plans depended heavily on FQHCs or serving the plans' Medicaid enrollees while other plans, even those that had contracted with FQHCs, did not. Plans expressed divergent views on FQHCs, which also reflected plan type as well as experience in contracting with FQHCs.

Plans Experienced with FQHC Contracting Viewed FQHCs Positively. In total, five of the 14 plans relied on FQHCs as key providers in the underserved areas where they existed--both contracting with more than half the FQHCs in the plan's service area and relying on the FQHCs to' serve a substantial number of the plan's Medicaid enrollees in the FQHCs' service areas (Table 11.3). In general, these plans had a positive view of their experiences with FQHCs, had contracted with the FQHCs for many years, and were Medicaid-focused plans. The two plans most articulate in praising the FQHCs expressed the following advantages: FQHCs are well located--viewed as critical because "you can't expect Medicaid enrollees to travel"--have culturally competent providers, know how to advocate for the patient (e.g., know what WIC is), are more open to urgent care and walk-ins, and know how to work with limited resources.

Two of these plans, however, emphasized that the FQHCs in their area needed to cooperate to more closely resemble an organized medical group. One of these plans hoped such a group could (1) form a single contact point for the plan, (2) improve the centers' ability to provide uniform data, (3) assume more risk, (4) agree upon medical management protocols, and (5) decide on a semi-exclusive contract with one plan rather than contracting with all available plans. The other plan ultimately hoped the group of FQHCs would do utilization review (e.g., prior authorization and referrals), quality assurance, pharmacy and therapeutics, case management, specialist physician contracting, credentialing, statistics and claims, and specialty payments. The plan acknowledged that most of the IPAs it contracts with do not do all these things either, though they do more of them than the individually contracted FQHCs do.

Other Plans Had Concerns about FQHCs' Interest, Efficiency, and/or Contract Arrangements. Generally, the other nine plans--mostly commercial-based plans with less experience with FQHCs--were ambivalent about contracting with FQHCs. For example, although four of these plans were pursuing additional FQHC contracts, their pursuit appeared largely driven by state requirements or incentives or the perception that the state favored this. There were three types of factors inhibiting FQHC contracting and/or more enthusiasm for contracting with FQHCs: (1) lack of interest by FQHCs and/or loyalty to a competing FQHC-based plan, (2) efficiency/price, and (3) contract arrangements.

Five plans (in three states) would like to contract with the FQHCs, but report the FQHCs have been uninterested, either because of having formed their own plan (in four of these cases) or for other unstated reasons, which may include the voluntary nature of Medicaid managed care in that area along with difficulties associated with the plan's contracting process. In areas where the FQHCs had formed their own plan, study plans expressed concerns that the FQHCs might encourage enrollees to join (or switch to) the FQHC-based plan rather than other contracted plans.

Efficiency/price concerns were expressed by three plans (in three states) that viewed the FQHCs as generally less competitive than other providers in their areas. In one case, the state required plans that contract with FQHCs to pay them the FQHC cost-based rate. The plan did so for one very isolated FQHC, but in another area it contracts with individual physicians within the FQHC to avoid the rule, and in another area the plan contracts with other available providers. The plan asserts that the FQHCs' cost-based rates are much higher than other providers' rates because FQHCs have been encouraged to increase their infrastructure beyond a competitive level. A second plan has pursued two contracts with FQHCs that are major providers in very underserved areas and views the FQHCs as essential there. However, it generally views FQHCs as lacking resources--data systems and nurse

triage systems, for example--to perform at the same level as other providers. The third plan had been in a highly competitive bidding situation and had committed to contracting with additional FQHCs, though the executive we spoke with viewed the FQHCs in that area as noncompetitive in that they have not developed a specialty network, tend to use graduates of foreign medical schools, are unable to meet the plan's reporting/tracking standards, tend to provide a more limited range of medical services than other providers, and are not the only providers available for contracting in their areas.

Contract arrangements were a reason why five plans did not contract with more FQHCs. Three of these plans tend to contract with large medical groups/IPAs and prefer to pass on most or all risk to these entities. These plans either only contracted with FQHCs through other groups or IPAs or said they had encouraged the FQHCs to join groups or IPAs in order to become a health plan provider. In one case the FQHC's lack of familiarity with the contracting process had led to a protracted negotiation period and "scrutiny of every word in the plan's standard contract." Another plan reported that one FQHC it would like to contract with is slowing the process by approaching the plan as though the plan must fit the FQHC's expectations rather than the reverse.

C. PLANS' USE OF ACCESS STANDARDS, MONITORING, AND ENABLING SERVICES TO HELP ENSURE SUFFICIENT ACCESS

Key Findings

- *Most plans had established access-related standards for enrollee maximums per primary care provider (usually a state requirement), appointment availability (usually a state requirement), and 24-hour coverage for their contracted providers (usually self-initiated to control emergency room use).*

Key Findings (continued)

- *Plans typically provided some direct services to support access, such as case management or transportation. Many of efforts like these went beyond state requirements.*
- *Plans whose core mission was service to the Medicaid population and that relied heavily on traditional Medicaid-serving providers offered more extensive enabling services than most commercial-based plans.*

The health plans we visited did not use quantitative approaches, such as staffing ratios, to guide their decisions about the number of primary care providers they needed, except that two of the three plans with staff-model components did use such ratios as a rough guideline for their staff-model centers. This is consistent with the previous HMO staffing study (Felt, Frazer, and Gold 1994). Instead, the health plans tried to ensure sufficient access by imposing access standards on their providers, monitoring provider availability and patient complaints, and establishing enabling services to help enhance access. In addition, most conducted patient satisfaction surveys that included questions about access.

1. Access Standards and Monitoring

Most plans had established access-related standards for the maximum number of enrollees per primary care provider, appointment availability, and 24-hour coverage for their contracted providers (Table 11.4).

Maximum panel sizes for primary care physicians were widely required but viewed as limited in effect. Six of the eight states required plans to ensure that each primary care provider was responsible for a limited number of enrollees. How the requirements were expressed and what was

TABLE II.4

PLANS' ACCESS-RELATED STANDARDS FOR PROVIDERS AND ACCESS MONITORING STRATEGIES

	All Plans"	Plans Focused on Traditional Medicaid-Serving Providers"	Other Plans[a]
Access Standards			
Maximum enrollees per primary care provider	11/13	5/5	6/8
24-hour coverage required	9/13	5/5	4/8
Provider must allow a minimum number of enrollees to join the plan	1/13	0/6	1/7
Appointment availability standards	12/13	4/5	6/8
Monitoring Strategies			
Specific requirements that providers self-monitor access	2/13	1/5	1/8
Monitoring by plan--light or no monitoring of providers[b]	1 1/14	4/6	7/8
Monitoring by plan--more intense monitoring of providers	3/14	2/6	1/8

"Number of plans with the characteristic/number of plans providing information on the characteristic.

[b]These plans for the most part had consumer satisfaction surveys and complaint-handling mechanisms in place, but did not do much systematic monitoring of their access standards.

viewed as maximum capacity varied. For example, one state has set a maximum of 1,200 enrollees per primary care provider (PCP) for PCPs that exclusively serve plan enrollees. Another state simply requires that plans ensure providers in their networks serve no more than 2,000 members per PCP. Two states had no related requirements.

For the most part, plans said they comply with the state requirements by informing providers about the maximum (e.g., through provider contracts). We sensed plans were sensitive about this issue not because of widespread noncompliance, but because a few providers might be at or over the limit and/or because they do not monitor provider compliance.[6] When asked how they identified access problems, no plans mentioned using these limits. Instead, they focused mostly on enrollee and provider complaints.

Issues previously reported concerning these limits still appear to exist, though we did not discuss the limits in as much depth in this study as in the last one (Felt et al. 1995). Specifically, network/IPA-model HMOs contract with providers that also contract with other health plans, and the HMOs neither keep nor have ready access to information about the providers' full patient loads. Further, the number of enrollees from the plan that any given provider could accept is subject to change depending on a variety of factors such as whether demand for that physician's services is growing from enrollees outside that particular health plan and whether the number or demand for other providers within the physician's group changes.

Plans in only two states reported interaction with states about specific information related to the limits and both were critical of the methods being used:

[6]We did not directly ask plans if they were enforcing the state required limits, as our purpose was not to audit the plan for compliance.

- One state has been monitoring plans' enrollment data for each primary care provider and has approached one of the study plans about a number of providers that appear to be operating at or just over the state's definition of full capacity. The plan disagrees that enrollees in this particular area face a real access problem, and some plan staff have begun suggesting to the state how it might refine the methodology used to assess capacity. (The plan also identified another area where it did believe access was a problem due to provider resistance to managed care, but where no problem has shown up in the provider-to-enrollee ratios.)

- A second state required as part of its contracting process that plans note next to each primary care provider's name how many plan enrollees the provider was willing to accept, up to a maximum number. However, one plan we visited that had called its providers to collect this information heard later that other plans reported more capacity and became skeptical about how systematic other plans were in obtaining this information.

Twenty-four hour coverage requirements were common. Of the 13 plans that provided information on coverage requirements, nine said they required that their providers offer 24-hour coverage. Round-the-clock coverage was important to plans to help minimize emergency room use, but was generally not a state requirement (only two states had related requirements). Most often, the plan specified that a primary care physician or clinical back-up staffer had to be available to talk to the enrollee.

Offering after-hours coverage by primary care physicians has not been easy or completely successful everywhere, we were told. One rural provider had lost a primary care physician over the change in coverage requirements, though it soon was able to fill the vacancy with a physician who would meet the requirements. Another FQHC established a contract with another area clinic to cover urgent care after-hours. Physicians at a third, where the providers had agreed to take on the after-hours responsibilities, reported relatively frequent after-hours calls; thus their workload--and patients' access to them--had significantly increased. One plan reported that it is considering contracting for urgent care in an area where providers are noncompliant with the requirement for 24-hour coverage; the plan is reluctant to enforce such requirements strictly since this is an area where every available provider

is needed for the provider network. A second plan also reported significant difficulties and having to "work with" the area FQHCs and other traditional Medicaid-serving providers in the inner city to accomplish 24-hour access.

Only one plan specified a minimum number of enrollees providers must be willing to accept to join the plan. One plan specified that primary care providers must be willing to accept at least 200 enrollees to join the plan. Thus, the plan can reasonably state that it has at least that much capacity, while in other plans physicians may cap new enrollment at any time and level.

Plans often set appointment availability standards, largely reflecting state requirements. Five of the eight states we visited (which included nine of the 14 plans in the study) have specific appointment availability standards for Medicaid-serving plans. These states' requirements vary by the types of appointments for which they specify an acceptable wait time, and in their assessment of what is a reasonable waiting period, though most specified that emergency care must be available immediately and urgent care within 24 to 48 hours (Rosenbaum et al. 1997). Thirteen of the 14 plans had some appointment availability standard in place, and seven of these discussed with us a fairly specific set of standards, which often but not always matched state requirements. Following the states' lead, these plans did not necessarily all cover the same types of appointments or have exactly the same standards. For example, several plans said an urgent care appointment must be available within 24 hours (one said 48 hours), and initial appointments for physicals within 30 days (or four to six weeks in one plan), while two other plans also set standards of one week and three weeks, respectively, for routine care appointments, another required specialty appointments within two weeks, and another required the availability of newborn visits within two weeks of birth.

Plans' monitoring of access requirements varied widely in intensity. Although access standards were often in place due to state requirements (for maximum panel sizes) or as goals (for

appointment availability), most plans were not emphasizing or closely monitoring them (Table 11.4). In explaining why the plan's annual access review consists of brief telephone interviews with providers rather than some more rigorous method like reviewing appointment books, one plan executive said: "We want to keep a good relationship with providers, not hassle them a lot."

Three plans performed monitoring of access standards/requirements that was intense relative to the other plans. These efforts were:

- When a member calls the plan's 24-hour hotline after hours, the hotline staff calls the provider. If the provider does not respond within 30 minutes, he/she is assigned a "point" for noncompliance with plan policy. When a provider's points total 25, their file is submitted for peer review. (Points can also be assigned for other reasons such as a complaint, but lack of availability after hours is one of the most common reasons providers get points.) Since the start of this system a year before our visit, as many as eight providers had reached the 25-point threshold. The plan's medical director corresponded with these providers, and the situation improved; the plan has reported a steady drop in that type of access problem.

- A mixed-model plan operates a "rewards and recognition" program on the network side. Providers receive additional capitation dollars based on performance according to a variety of criteria including appointment availability and wait times (which the plan monitors for Medicaid as well as overall), performance on HEDIS indicators, and scores on an independent satisfaction survey.

- A third plan has four provider service representatives who monitor waiting times on site (standard is no more than one hour for urgent and under two hours for nonurgent) and three who make "ghost appointments" to monitor appointment availability. The plan found the compliance rate has improved to nearly 100 percent. (The plan and its providers are owned by the same organization, giving the plan a relatively high degree of leverage over its contracted providers.)

Plan monitoring activities also varied in type. Many plans focused their access efforts on ensuring 24-hour coverage. Five plans call provider offices, often after hours, to test response. Most often, the test is not on behalf of a real patient. One plan noted that they have to be careful how much test calling they do--providers do not appreciate being awakened in the middle, of the night when the problem is not real.

Only two of the study plans ask providers to conduct access reviews. One plan sends its major providers (those with 1,000 or more enrollees) materials for a self-review developed by the California Coalition for Managed Care, which systematically reviews access and covers appointment availability standards. A second plan, influenced by National Committee for Quality Assurance (NCQA) requirements, has recently begun requiring vice presidents of its contracted IPAs to make random test calls to providers to assess typical wait times for appointments.

Nearly all the plans conducted an enrollee satisfaction survey that included questions about access, though only one plan discussed the survey results with us as a particular emphasis for the plan. That plan's results suggest that such surveys can be useful tools for monitoring access, although the responses of most plans suggest surveys are not being used in this way now. One plan had found through an apparently rigorous survey conducted by an independent contractor that its staff-model side was better at meeting urgent care needs, while its IPA side was better at meeting needs for routine care. This information combined with other information suggesting providers in the city in our study do not offer after-hours care (despite the plan's requirement) has led the plan to consider contracting for urgent care in that area.

Follow-up on enrollee complaints still viewed as key to identifying access problems. While many plans reported having various access requirements and some monitoring in place, most access issues are discovered through following up on enrollee complaints. One plan also noted that issues involving access to specialists are found through complaints by primary care providers.

2. **Enabling Services Provided by Plans Complement/Enhance Use of Primary Care**

Plans typically provided some direct services to support access to primary care, such as case management or transportation, citing two primary motivations. First, all the plans viewed Medicaid enrollees as having special needs relative to other enrollees and believed that reducing emergency

room use was key to serving these enrollees well and within the plan's capitated payment from the state (i.e., they viewed the programs as cost-effective). Second, some of the studied states asked plans about available enabling services as part of the bidding process for contracts, and some required certain types of services to be in place. The plans emphasized, however, that state requirements tended to be minimal and that most plans had more than the required services. A few plans' services also appeared driven by marketing considerations. For example, one plan believes its transportation service offers it a substantial advantage in attracting enrollees. Another reported scaling back its transportation service when competing plans scaled back theirs.

Most health plans' enabling services fell into one of seven categories: transportation, language-related, reminder systems, other outreach, 24-hour nurse advice line, health education programs, and targeted case management. A few plans also provided social work services. The intensity, creativity, and types of the programs in place varied widely among the plans (Table 11.5). For example, one plan has a staffer devoted to member education in the Medicaid population who identifies high emergency room users and targets them for home visits and other education. The same plan holds health education classes that include classes for pregnant teens and classes on parenting skills and has funded a public health nurse to give immunizations in homes. In another plan, enrollees can call a multilingual health information line to access education messages on subjects like HIV and pregnancy. That plan also employs 11 "access specialists" who provide as-needed services such as visits to welcome new members who cannot be reached by telephone and follow-up calls to enrollees who do not show up for appointments.

Appendix D offers an overview of each type of enabling service and provides a brief description of some of the most creative and well-used programs we encountered, which may be of interest to other plans.

TABLE II.5

ENABLING SERVICES PROVIDED BY HEALTH PLANS

Plan	Transportation	Language-Related	Reminder Systems	Other Outreach	Nurse Advice Line (24-hours)	Health Education Programs	Targeted Case Mgt.	Social Work	More or Less Extensive Set of Enabling Services
1	✓	+		✓	✓	+			MORE
2		✓		✓					LESS
3		✓	✓			✓			LESS
4		✓		✓		✓			LESS
5		✓	✓		✓	✓			LESS
6	✓	+		+	+	+	+		MORE
7	✓	✓	✓	✓		+	+	✓	MORE
8	✓	+							LESS
9		✓	+	✓		✓			LESS
10	✓	✓	✓	✓	✓[b]	✓	+	✓	MORE
11	✓	n.a.[c]	+	✓		✓			LESS
12	+	+		✓	✓		+		MORE
13	✓	✓		✓		✓	+	✓	MORE
14	✓	✓	✓	+		+	+	✓	MORE
Number of plans with a program	**9**	**13**	**7**	**11**	**5**	**11**	**6**	**4**	**7 LESS 7 MORE**

KEY: ✓ = program or effort in place
\+ = plan emphasizes this, or it was especially creative, well used, etc.
Blank = no program or in a few cases missing information

NOTE: For mixed-model plans (2, 5, and 11), this table notes only programs available to network-model Medicaid enrollees. In all cases, additional programs were available to staff-model enrollees.

"Plans classified as having more extensive enabling services had at least 5 types of programs in place and at least one that the plan emphasized or that was especially well used or creative ("+").

[b]24-hour hotline may not be staffed by a nurse.

[c]Not applicable--plan indicated there was no need for language-related services in its population.

The seven plans with the most extensive enabling services had the following characteristics:

- Most of these plans (five of the seven) shared a focus on the Medicaid population (e.g., Medicaid comprised at least 60 percent of total enrollment) and had built their provider networks largely on traditional Medicaid-serving providers.

- They **all** shared the view that enabling services were needed to assure access to primary care for the Medicaid population, and thus financial success for the plan, by reducing emergency room use, hospitalizations, and the need for specialist visits.

- The two commercial-based plans with more extensive enabling services were the two that had developed dedicated Medicaid products.[7]

In contrast, we observed the following about the plans that had fewer enabling services in place:

- ***The two plans that were commercial-based and contracted with large groups/IPAs at full financial risk tended to provide fewer and more market-driven enabling services.*** One of these plans (with both a staff-model and a network component) explained that it has no incentive to provide enabling services to contracted providers' enrollees because any savings from reduced utilization would benefit the contracted group, not the plan. However, some of its contracted providers have expressed interest in using the more extensive enabling services the plan provides to its staff-model enrollees, and the plan says it may offer these to the network enrollees where the groups are willing to pay the price.

- ***The mixed-model plans provided fewer enabling services for their network-model enrollees than for their staff-model enrollees.*** **All three** of the mixed-model plans followed, this pattern. One plan, as just explained, explicitly related this to where the financial benefits of these programs would accrue (to the contracted providers, for the network side). In the other cases, additional factors may have been geography and how the plans are administered. That is, the staff-model sites are located in a specific core service area, while the network is spread over a large area of the state, making it more difficult to organize health education classes, to find case managers/social workers familiar with services available in each area, and to arrange for access to cost-effective urgent care that could be coordinated with the enrollee's primary care provider. Also, all these plans had **certain executives who were primarily concerned with staff-model** services and who were especially focused on effective health care delivery, and others who were concerned primarily with network-model services, who tended to be more

[7]Although these were the only two commercial-based plans in this study that provided more extensive enabling services, the study preceding this one included a large commercial-based plan without a separate Medicaid product that nevertheless provided extensive enabling services.

focused on issues around provider contracting. Given this organization, there was probably no reason why the two sides would develop parallel services.

- ***The rural-based plan found less need for formal enabling services in the rural environment than it did as it expanded into a more urban area.*** *The* rural, commercial-based plan did not find a need for most formal enabling services such as case management or outreach in rural areas, explaining: "The nice thing about smaller communities is everyone knows everyone. People are able to acquire services partly because people know each other and there is a level of information and feedback that's informal but works." Nevertheless, the plan had an aggressive system of reminders and incentives for immunizations. This plan was developing more enabling services as it expanded into an inner-city area, which it has found more challenging in terms of coordinating services for patients.

This chapter addresses how the 23 safety net providers we visited are faring under Medicaid managed care, compares the characteristics of thriving and struggling providers, and offers insights about the key factors influencing outcomes to date. We also discuss operational changes safety net providers have been making in response to managed care that may be affecting access. The chapter concludes by summarizing providers' perspectives about the strengths and limitations of Medicaid managed care to date. In this chapter, we discuss the experience of the 4 local health departments separately from the 19 other safety net providers ("health centers") we visited, because health departments faced unique issues related to their broader public health mission and public ownership.

In part because the study focused on areas that had experienced the most rapid growth in Medicaid managed care, it included many areas that were in the early stages of converting Medicaid to more advanced managed care arrangements. As a result, we were able to observe the dynamics between health plans and providers when plans were still forming and expanding their provider networks. In interviews with traditional providers, valuable insights surfaced about experiences to date with managed care, the factors associated with more-and-less successful experiences, and the challenges facing traditional providers as Medicaid managed care expands and evolves. However, in many of the markets programs were either very new or were expected to change significantly in the near future, limiting our ability to assess the "bottom line" for traditional providers under fully implemented Medicaid managed care programs.

A. STABLE OR THRIVING PROVIDERS AND **THOSE THAT ARE MORE** VULNERABLE

Key Findings

- *Most of the health centers were participating in Medicaid managed care and had done well financially, or had at least broken even, to date.*
- *Several factors have been key to these more positive experiences:*
  - *Strong payment rates under managed care arrangements, which in some cases are even better than cost-based reimbursement*
  - *Cost-based reconciliation that provides some health centers with wraparound payments to subsidize below-cost managed care payments*
  - *Operational and administrative improvements that have lowered costs and made some health centers more efficient*
- *The health departments and some of the health centers faced greater challenges. Most of the health departments were transferring their primary care operations to other community providers and increasing their focus on enabling services and traditional public health functions.*

Most traditional Medicaid providers we examined have survived and some have even prospered amid substantial growth in Medicaid managed care. Using information from site visit interviews and from the Bureau of Primary Health Care's central database, we examined data for the 1993 to 1996 study period to characterize trends in the following: total revenue, revenue from insurers, patient and encounter volume, net income under managed care, primary care staff FTEs, and the number and size of clinic sites. Provider organizations showing declines in two or more of these areas were flagged as potentially vulnerable (this process identified nine providers). We then compared these nine

providers to an original list of vulnerable providers developed by the site visit teams. We decided to remove two providers from the original list for these reasons:

- One CHC had lost money and staff FTEs under its managed care contracts, but the managed care deficit had been offset by state reconciliation payments and the staff decline had been temporary (its two physicians had taken personal leaves for family reasons but had since returned full time). This health center, however, will be in a much more vulnerable position if its state eliminates cost-based protections for FQHCs.
- Another CHC had also lost money under managed care, and its Medicaid revenues had declined. But unlike a nearby FQHC, it had succeeded in holding onto its Medicaid patients amid greater competition resulting from the shift to mandatory enrollment. It is also eligible for surplus payments as a part owner of a FQHC plan (although at the time of the visit it was unclear whether the plan would have any surplus to distribute).

Among the remaining seven vulnerable providers, four are health centers and three are health departments.

Most of the Health Centers Had Fared Well To Date. As shown in Table 111.1, 15 of the 19 health centers had fared well or at least not suffered with the expansion of Medicaid managed care in their service areas. The health centers that had survived well include those of all sizes, all contracting strategies (including not contracting at all), and all levels of managed care enrollment. Health centers are also doing well in both mandatory and voluntary managed care environments, with and without special cost-related protections. Those that resisted participating in managed care do not appear to be particularly vulnerable, in part because most are dominant Medicaid providers in their markets, and they have put resources into expansions and upgrades of their facilities and clinical capabilities. The feature that most of the successful health centers share is an increase in Medicaid's share of total revenue since 1993. A few stable health centers experienced a slight decline in Medicaid revenue, but had managed to retain their Medicaid patients despite increased competition.

TABLE III. 1

COMPARISON OF HEALTH CENTERS THAT HAVE FARED WELL AND THOSE THAT ARE STRUGGLING

Characteristic	Number of Health Centers Total = 19	
	Stable or Doing Well	Struggling and Vulnerable
Total	15	4
Provider Type		
CHC	10	3
Other FQHC	3	1
Other	2	0
Size		
Smaller (Under 10,000 users)	6	1
Larger (10,000 or more users)	8	3
unknown	1	0
Contracting Strategy		
Contract with all willing MCOs	6	2
Contract with preferred MCOs	8	2
Do not contract with any MCOs	1	0
Level of Competition Among Medicaid Providers in Their Area		
High	5	4
Moderate	4	0
Low	6	0
Trends in Proportion of Revenue from Medicaid Since 1993		
Increase	10	0
Decline	3	4
Unknown or not available (new start)	2	0
Plan/Network Involvement		
Close ties with an FQHC plan	4	2
Member of an FQHC network	3	0
No involvement	8	2

TABLE III. 1 *(continued)*

Characteristic	Number of Health Centers Total = 19	
	Stable or Doing Well	Struggling and Vulnerable
Number of Managed Care Enrollees, 1995		
None	5	1
1-5,000	6	2
5,000-l 0,000	3	0
10,000 or more	1	1
Proportion of Users in Managed Care, 1996		
Under 10 percent	3	0
1 O-30 percent	6	2
More than 30 percent	6	2
Proportion of Revenue from Managed Care, 1995		
None	3	1
l-20 percent	2	2
20-40 percent	7	0
unknown	3	1
Financial Incentives Under Managed Care Contracts for Specialty and/or Hospital Care		
Surplus sharing	3	2
Surplus and loss sharing	2	0
None	9	2
Not applicable	1	0
Enrollment in Medicaid Managed Care to Date		
Voluntary	8	3
Mandatory	7	1
FQHC Cost-Related Reimbursement Under Managed Care		
Available/received	8	1
Not available/not received	7	3

SOURCE: Mathematica Policy Research analysis of Bureau Common Reporting Requirements data (1993 and 1995) for federally funded CHCs, and information collected on site visits.

MCOs = managed care organizations.

Although small numbers make it difficult to draw firm conclusions, the four vulnerable health centers share a few common features. They are all located in highly competitive areas for Medicaid providers, they have experienced declines in Medicaid revenue as a proportion of total revenue, and they are not receiving FQHC cost-related subsidies or wraparound payments. The decline in Medicaid revenue for some is due to lower reimbursement, while for others it is related to the loss of Medicaid patients.

Site visit interviews provided further insights about the forces that have most influenced health center experiences to date:

- ***Managed Care Payment Rates.*** Managed care payments for many of the more successful health centers have been generous or at least adequate. In addition, several health centers have received surplus or bonus payments either as part-owners of a FQHC plan or through incentive programs tied to utilization of specialty and hospital care. Although about one-third of the health centers would be interested in taking on more risk for, and reaping the benefits from specialty and hospital care, most still felt most comfortable limiting their capitation payments to primary care and sharing in incentive programs that limit the amount of downside risk. Most of the health centers that are struggling cite low payment levels as a major factor, combined with inadequate coverage for enabling services that the health centers feel they must continue to provide.

- ***Cost-Based Subsidies or Wraparound Payments.*** One health center is surviving despite low managed care capitation payments because it has received supplements as an FQHC from the state Medicaid program to cover its losses. This arrangement, combined with the fact that the health center has few nearby competitors, has shielded the health center to date from most incentives (positive and negative) related to managed care. Health centers in another market have been unsuccessful in securing cost-based supplements to offset losses under their managed care contracts, although they are legally entitled to this.'

[1] Under current Medicaid law, states operating Medicaid managed care programs under Section 19 15(b) waiver authority are not permitted to waive their obligation to pay FQHCs on a reasonable cost basis. However, some states build the FQHC money into payments to health plans and then expect FQHCs to negotiate a rate that will then be "deemed" cost reimbursement. Health centers in some markets have concluded that it is not worth fighting to get additional money because they will risk losing the contract and/or not being given an adequate number of enrollees.

- ***Managed Care Marketing and Enrollment Changes.*** In markets where enrollment in Medicaid managed care was already mandatory, rules regarding marketing and default assignment[2] have had a significant impact on some health centers' Medicaid caseloads and revenues. One health center has experienced a major loss of Medicaid patients due mainly to competition but worsened by the fact that the FQHC plan with which it contracts didn't receive any default assignments because they scored too low in the bidding process. Health centers in another market are doing very well under their contracts with an FQHC plan, but competitive bidding wars keep changing the playing field and raise concerns about whether the FQHC plan will remain viable in some of its markets.

- ***Increased Competition Among Medicaid-Serving Health Plans.*** In four study markets, Medicaid managed care was about to convert from voluntary to mandatory enrollment. One health center experienced a substantial decline in Medicaid patients and revenues when its long-standing ally health plan decided it needed to expand its provider network to remain competitive. Although managed care payments to this health center were quite generous, it may lose more paying patients unless it succeeds in contracting with other health plans and promoting loyalty among existing Medicaid patients.

- ***Operational and Administrative Obstacles.*** One of the less stable health centers has faced enormous difficulties integrating into managed care because its mission has been to provide a substantial amount of nonmedical care in keeping with its holistic practice approach and attention to the mental health, social service, and spiritual needs of its patients. This health center is further disadvantaged because it does not receive federal primary care grants. Another struggling health center claims that it is losing money under its managed care contracts but admits that limitations with its current information systems prevent it from really analyzing its financial status. This health center's 11,000 enrollees are spread out over nearly a dozen health plans, exacerbating administrative problems and taxing their already limited management capabilities.

Health Departments Appear to Face Greater Challenges. Of the four health departments visited, three have had difficulties sustaining their primary care operations, and only one seems well positioned as a primary care provider under Medicaid managed care. Key attributes of the stable versus vulnerable health departments are shown in Table 111.2. Based on this small number of sites, it appears that the one health department with a more successful primary care practice has benefitted

[2]State Medicaid agencies use default assignment rules to assign beneficiaries to a health plan when they do not select one at the designated time under a mandatory managed care program.

from a solid and supportive county government, lucrative contracts with a FQHC-owned plan, and eligibility for cost-based reimbursement as a FQHC for its primary care operations. Recent developments, however, suggest that this health department may lose its FQHC status except under the limited scope of its homeless program. The struggling health departments varied in their size, managed care contracting approach, and level of managed care involvement. None of them are eligible for FQHC reimbursement, nor are they involved in a FQHC plan or network.

In part but not solely because of managed care, the health departments have been rethinking their role as direct providers of primary care. All view their primary missions as serving the indigent/uninsured and in providing traditional public health services related to disease prevention and health promotion. Their primary care practices were added at a time when there were more serious primary care access and supply problems for low-income populations. As managed care and other forces (such as improved reimbursement) expanded the numbers of Medicaid-serving providers, the health departments were forced to reconsider their role and competitive position as primary care providers.

Two of the health departments ultimately decided that they could not compete effectively as primary care providers. Instead, they will partner with other providers while continuing to deliver wraparound social work, outreach, and prevention services. They hope this will enable them to focus more attention and resources on access-enhancing services as well as on broader public health objectives. The new partnerships will also result in more comprehensive services delivered across a broader age spectrum (currently one health department focuses on children, and the other serves mostly adults). The third struggling health department has a much better foothold in primary care,

TABLE III.2

COMPARISON OF HEALTH DEPARTMENTS THAT HAVE FARED WELL VERSUS THOSE THAT ARE STRUGGLING

Characteristic	Number of Health Departments Total = 4	
	Stable or Doing Well	Struggling and Vulnerable
Total	1	3
Size of Primary Care Patient Population		
Smaller (Under 10,000 users)		2
Larger (10,000 or more users)	1	1
Contracting Strategy		
Contract with all willing MCOs		1
Contract with preferred MCOs	1	1
Do not contract with any MCOs		1
Level of Competition Among Medicaid Providers in Their Area		
High	1	3
Moderate		
Low		
Plan/Network Involvement		
Close ties with a FQHC plan		
Member of a FQHC network		
No involvement		3
Number of Managed Care Enrollees, 1995		
None		1
1-5,000		1
5,000-l 0,000		
10,000 or more		1
Enrollment in Medicaid Managed Care to Date		
Voluntary		2
Mandatory	1	1
Cost-Related Reimbursement Under Managed Care		
Available/received		
Not available/not received	1	3

MCOs = managed care organizations

but is coping with major infrastructure and staffing problems because of a near-bankrupt county government. Its fate hinges on the county's fiscal situation and on whether it can market itself as a stable system to managed care organizations, providers, and patients.

Factors Influencing Managed Care Participation Strategies. The actions and requirements of individual health plans appear to have had less influence on provider responses than the advent of Medicaid managed care more broadly and the collective actions of health plans within the market. Payment rates and related financial incentives, however, do tend to vary across plans and to influence how health centers respond. Health centers in about half the study markets had been contracting exclusively or preferentially with one health plan that was paying significantly better than the competitors. Without exception, these health centers were being reimbursed under the more lucrative contract at least as well as under cost-based reimbursement. Another health center was losing money under its managed care contracts, but was being made whole through cost-based reconciliation with the state. The availability of cost-based reimbursement also played a major role in the decisions of two health centers not to participate in managed care until the program moved to mandatory enrollment. In contrast, eight health centers have faced low rates under all their managed care contracts, limited financial incentives, and no cost-based reconciliation and have therefore had to focus more on cost cutting and improved efficiency. Health centers in these markets have felt more pressure to contract with many plans to protect their market share.

Probably the most important "environmental" factor we observed was the nature of enrollment provisions for the Medicaid managed care program. In all but one of the markets, mandatory Medicaid managed care had already been implemented or was planned for implementation during the coming year. In contrast to voluntary enrollment, mandatory programs typically centralize the enrollment process and prohibit certain marketing practices, limiting the amount of direct influence

plans and providers can have over enrollment decisions. Also, the rules for assigning people who do not select a plan introduce even greater uncertainties for plans and providers, particularly because such a large proportion end up being enrolled in this manner (30 to 50 percent in many markets). In the one market where the FQHC plan was excluded from the default assignment pool (because it scored too low), the plans' enrollment numbers have been lower than expected, forcing their FQHC providers to negotiate with other plans to remain competitive. In another market, competitive bidding wars intended to limit and rank the plans allowed to compete in each market have caused turnover and confusion because the spots are recompeted frequently and enrollee assignments are based in part on a plan's ranking.

Although reimbursement and enrollment issues appear to have had the greatest influence on health centers, managed care access requirements and utilization management techniques have affected some health centers. One center noted that managed care access requirements helped it persuade its physicians to add evening and weekend hours. Several health centers were responding constructively to feedback from their plans and/or patients that indicated problems with waiting times and after-hours coverage. Most of the health centers had added hours in recent months, in part because of competition engendered by managed care, but also because of the emphasis managed care places on alternatives to the emergency room.

B. CHANGES IN THE OPERATIONS OF SAFETY NET PROVIDERS THAT MAY BE AFFECTING ACCESS

Key Findings

- *Safety net provider organizations made improvements in their operational and administrative systems to become more competitive with other provider organizations.*
- *These improvements--including additional hours and sites, better after-hours coverage, and more focus on customer service--have likely enhanced access for Medicaid enrollees and other patients, including the uninsured.*

Recognizing the need to become more competitive, many safety net provider organizations had made improvements in their operational and administrative systems: adding hours and sites; improving after-hours coverage; reducing wait times, walk-ins, and no-shows; upgrading clinical standards; and focusing more on customer service. These general improvements have likely enhanced access for patients, including the uninsured.

More Hours of Operations and Sites. As shown in Table 111.3, 11 provider organizations added hours of operation and/sites. Those that added sites, all dominant provider organizations in their areas prior to the expansion, hope that the newer facilities will help attract new patients, retain current patients, and strengthen their position with area health plans and hospital systems. Roughly a third of the providers had either added 24-hour coverage (several FQHC look-alikes, a health department and one CHC) or introduced nurse triage systems to handle after-hours calls more effectively, An equal number had either added new staff or designated certain staff to coordinate managed care referrals and provider issues.

Triage Systems to Improve Patient Flow. Three provider organizations had recently added triage systems during operating hours to handle walk-in patients more efficiently. Two health centers noted that they make appointments for walk-in patients unless they are sick. Another health center operates separate check-in and waiting processes for walk-ins and patients with appointments. Those with appointments do not wait as long, which may encourage the walk-ins to schedule appointments.

Addressing High Rates of No-Show Patients. Most health centers deal with high no-show rates by double- or triple-booking appointments. Many send out reminder post cards and/or attempt to call patients the day before, but these approaches miss the people who have moved since their last appointment and those without phones (typically 30 to 40 percent cannot be reached). Other methods used to combat no-shows include calling patients after the missed appointment and/or sending an outreach worker to them. One of the health departments reports having had great success in reducing no-shows through its outreach program: community health workers visit noncompliant patients in their homes try to help address barriers, and encourage them to keep their appointments.

Information System Upgrades. Six providers have upgraded their management information systems (MIS) or are in the process of doing so. The newer systems are designed to meet the demands of managed care for utilization management and financial/cost analysis. Health centers are also upgrading their systems for scheduling and tracking appointments, and some use automated systems to track patients' needs for immunizations or preventive screening tests. However, many of the health centers still have inadequate information system capabilities for the managed care environment. These health centers recognize the failings of their current systems, but lack the capital and, in some cases, the expertise to make this transition. Several currently lack the capability to analyze performance under their managed care contracts or to assess the adequacy of proposed capitation payments.

TABLE III.3

RECENT OR PENDING ADMINISTRATIVE AND OPERATIONAL CHANGES MADE BY STUDY SAFETY NET PROVIDERS

	Number of Provider Organizations Total = 23
Improvements/Enhancements	
Expanded hours	11
Expanded sites	11
New or improved after-hours coverage	7
Added or designated staff to handle managed care coordination	7
New strategies to address walk-ins (e.g., triage)	7
Improved or new management information systems	6
Improved customer service/customer relations	6
Enhanced scheduling/appointment systems	4
Enhanced staff productivity	4
Accreditation	2
Began requiring that physicians be board certified	1
Problems/Cuts	
Reduced staff	5
Reduced service(s) Outreach (1) Ancillaries (1) Primary care (3)	5
Reduced sites	3

Quality Assurance Improvements. Many health centers have made significant changes in their quality assurance programs, including two that have received or are seeking accreditation and another that now requires its physicians to be board certified and to follow health center patients who are hospitalized. In preparation for managed care, one health center expanded its facility, upgraded its MIS, cross-trained its staff, and successfully sought and received Joint Commission on Accreditation of Healthcare Organization (JCAHO) accreditation. At the time of our visit, this center was negotiating its first managed care contracts, and while not regretting its push for accreditation, was finding that its new status did not necessarily warrant a more favorable contracting position. Instead, health plans in their market were pushing them to subcontract with an IPA.

Patient Satisfaction and Service. Recognizing that Medicaid patients now have more options and that providers must work harder to retain them, six providers talked about how they are focusing more on patient relations and satisfaction. This includes conducting patient satisfaction surveys and then acting on the results, training front-desk staff to be more friendly and accommodating, training all staff to be better marketers of the health center, and engaging in outside marketing efforts. Several providers mentioned that they have made improvements in appointment and scheduling systems to reduce waiting times.

Scaling Back on Primary Care or in Other Areas. Three of the four health departments have reduced their primary care capacity (staff, services, and sites) since 1993. Two of the health centers have also had significant **staff** reductions, although they have coped with this to date without having to make significant changes in their scope of services. One of these health centers has already eliminated its pharmacy services and the other is worried about sustaining enabling services but has managed to sustain them thus far. Another health center has cut back on some of its outreach services for managed care enrollees. Other providers have coped with the loss of staff and revenues

TABLE III.4

PROVIDER PERCEPTIONS OF BENEFITS
AND DRAWBACKS TO MANAGED CARE

Managed Care Attribute	Number of Provider Organizations Total = 23
Benefits	
Encourages administrative and quality improvements	12
Management information systems/administrative	11
Quality/accreditation	7
Better hospital coverage	2
More lucrative than fee-for-service (under at least one contract)	9
Better after-hours coverage, triage systems, and/or expanded hours	8
Expands number of providers willing to serve Medicaid	7
Enhanced benefit package	5
Predictable cash flow and/or greater flexibility in use of funds	3
Encourages cost efficiency	3
Encourages greater attention toward patient service/satisfaction	3
Better coordination of care	1
Drawbacks	
Reduced revenues for serving the uninsured	14
Lack of funding for case management and outreach	11
Inadequate coverage for primary care	7
More administrative burdens (paperwork, prior authorization, referrals)	7
New Medicaid providers not as skilled in serving Medicaid population, and/or not committed in it for the long-term	6
Not enough or the right types of specialists available	5
Enrollment problems (assignments too low or incorrect, delays in getting undated member lists)	5

TABLE III.4 *(continued,)*

Managed Care Attribute	Number of Provider Organizations Total = 23
Patients confused about managed care rules and procedures	5
Biased selection and/or not receiving enough "nonuser" enrollees	4
Inadequate feedback from plans about performance	4
Limited opportunities to share in the savings from specialty and hospital care	4

by implementing cost-cutting measures and increasing staff productivity. One provider, which describes itself as being "on the bleeding edge," has managed to survive amid substantial revenue cuts because so many of its physicians donate their time or have agreed to work for substantially lower salaries.

C. PROVIDER PERCEPTIONS ABOUT MANAGED CARE'S BENEFITS AND DRAWBACKS TO DATE

Key Findings

- *Most provider organizations thought managed care motivated improvements in cost efficiency and quality of care, and many cited increases in the supply of Medicaid-serving providers.*
- *One-third of the health centers reported losses under their managed care contracts and were especially worried about their ability to sustain the same levels of enabling services and uncompensated care in the future. Some reported that their financial difficulties under managed care have been exacerbated by high proportions of user versus non-user enrollees, and by users with higher-cost conditions such as HIV, serious mental illness, and substance abuse.*

Although a few providers saw only benefits or only drawbacks, most appear to view managed care as having about equal positives and negatives. Table III.4 summarizes the range of benefits and drawbacks noted, along with the number and percentage of providers that mentioned each one.

1. Administrative and Quality Improvements Top the List

Roughly half of the provider organizations thought managed care had motivated improvements in administrative systems and in meeting external quality standards: encouraging upgraded information and appointment systems, pushing health centers to become accredited, encouraging or requiring physicians to be board certified, and pushing some health centers to become more involved

in following their patients in the hospital. Several respondents thought managed care had helped FQHCs to become more cost efficient, as opposed to the FQHC program, which they saw as promoting inefficiency and escalating costs. Increased competition from plans and providers has also motivated health centers to focus more on patient satisfaction and "customer service." As mentioned earlier, a number of health centers were training or planning to train their staff to be more friendly and helpful, and to be better marketers of the health center.

Nine provider organizations had experienced better financial outcomes under managed care, either from ample capitation/reimbursement rates or the opportunity to share in surpluses and other incentive programs related to specialty and hospital care (only two providers currently bear downside risk for this care). Several provider organizations appreciate the more predictable cash flow and flexibility associated with capitation payments. Managed care was also seen by many (eight) to have encouraged providers to expand their operating hours and to add triage systems for handling walk-ins and calls after hours. Health centers in seven markets also perceived managed care as having increased access for Medicaid populations to specialists and primary care physicians that had previously limited their involvement in Medicaid and/or managed care.

2. Enabling services and Care for the Uninsured Have Been Sustained to Date but May Be Threatened

To date, provider organizations have been able to sustain enabling services and care for the uninsured, either because Medicaid managed care revenues have been ample or because providers have been able to use grants and reserves to finance this care. However, most provider organizations are concerned about their ability to sustain the same level of service in the future (this issue is discussed further in Chapter IV). Although safety net respondents viewed some health plans as supportive and skilled in trying to meet the needs of low-income populations, other plans were characterized as "just doing the bare minimum". As one health center respondent put it: "The health plans are great at short-

term crisis-case management, but our patients face many obstacles and need support over the long haul." One of the health departments is trying to get its state to require health plans to subcontract with local health departments for outreach and case management because it believes the plans do not have the skills or incentives to make enough effort in these areas.

In addition to their concerns about enabling services and the uninsured, seven provider organizations complained that managed care payments were not even adequate to cover the costs of routine primary care. An equal number complained about excessive paperwork and administrative demands related to managed care. We also heard concerns about health plan provider networks: difficulties in some markets finding enough or the right types of specialists and fears that providers new to Medicaid lack appropriate skills and may abandon the program when they see how hard it is to serve this population well and profitably.

Health centers in several markets are struggling with what they perceive as a disproportionate share of more costly enrollees. Some think that they have not received enough "nonuser" enrollees, while others are contending with many enrollees with costly conditions such as HIV/AIDS and/or mental illness. Because these health centers are finding managed care payments inadequate for existing populations, they are especially anxious about further expansions of the disabled and poor elderly into managed care. Several health centers are worried that mental health services are inadequately covered and inappropriately delivered under managed care (although one CHC specifically mentioned that mental health coverage had improved under managed care). In one market where mental health services are "carved-out" and managed through a separate managed care company, two provider organizations noted problems with coordination between plans and physicians, and one reported that patients are being prescribed the wrong medications and otherwise receiving substandard care through the carve-out program.

Provider organizations in the two areas with mandatory enrollment noted many problems with the assignment process: people being assigned incorrectly, unfair default assignment practices, and problems not getting enough new patients. These problems tend to be most acute during the transition into a mandatory program, and since most of the study areas were still in transition it will be important to monitor whether the problems persist over time. Other problems noted by several provider organizations include inadequate patient education about managed care rules and procedures, inadequate feedback from plans on provider performance, and plans' unwillingness to let providers share in the savings for specialty and hospital care.

IV. PUTTING IT TOGETHER: EFFECTS OF MEDICAID MANAGED CARE ON THE AVAILABILITY OF PRIMARY CARE SERVICES FOR LOW-INCOME RESIDENTS OF THE GEOGRAPHIC AREAS STUDIED

Recalling the framework established in Chapter I, this chapter presents our findings on how health plans' strategies for providing primary care--and Medicaid managed care more generally--have affected the availability of primary care services in our study communities. The following types of effects on service availability are considered:

- Direct effects on provider supply
- Changes in the flow of dollars and patients
- Changes in the availability of enabling services
- Changes in enrollees' understanding of how to access care

At the end of the chapter, we summarize key changes under way in the study states that may affect access in the future. Overall, to date, Medicaid managed care has had a positive effect on the availability of primary care services to Medicaid enrollees, though the policy and market changes under way suggest the future may be different. There were no reported negative effects on access for the uninsured, and some of the benefits that accrued to the Medicaid population--including increased number of safety net provider sites and extended hours of operation--also benefitted the uninsured who use the safety net providers.

A. DIRECT EFFECT ON PROVIDER SUPPLY AND IMPLICATIONS FOR COMMUNITY ACCESS

Key Findings

- *The number of primary care providers available to Medicaid beneficiaries increased in the underserved areas in our study as a result of the efforts of health plans (especially commercial-based plans) and Medicaid managed care in general.*
- *Health plans and safety net providers expressed significant concern that the newly available providers might not be providing care in a culturally competent way that considers the barriers faced by low-income enrollees, and only one plan had a specific method in place for dealing with related problems.*
- *Although we were not able to quantify the provider capacity of the safety net, our findings suggest Medicaid managed care did not change the supply of providers available to uninsured residents in most of the areas we visited. The safety net providers continued to serve the uninsured residents to the same extent as before Medicaid managed care, but providers who had newly opened their practices to Medicaid were reported not to be opening them to the uninsured.*

Health plans--especially commercial-based plans--and Medicaid managed care programs more generally, have been important factors in increasing the supply of primary care physicians available to Medicaid beneficiaries. The increased provider supply for Medicaid is mostly due to the increased willingness of commercial-oriented providers to serve Medicaid, rather than an increase in the number of providers practicing in underserved areas.

The provider options for the uninsured residents of the areas we visited have not increased and continue to include FQHCs and other safety net providers. However, in some cases the FQHCs had

added sites or expanded hours of service due to managed care, benefitting both Medicaid and non-Medicaid users.

1. Managed Care's Influence on the Number of Primary Care Providers

At least six of the 14 HMOs we visited increased the number of primary care providers available to Medicaid enrollees from among the providers already located in their service areas.[1] The three commercial-based plans that integrated Medicaid enrollees into their existing provider networks that were developed for commercial enrollees increased the availability of primary care providers the most, often by offering providers better rates than Medicaid fee-for-service or by paying the same for Medicaid as for commercial enrollees. For example, according to a health plan executive, before Medicaid managed care, only 32 to 34 percent of physicians would see Medicaid beneficiaries in the small, urban area that is the plan's core service area. Now, 99 percent see Medicaid enrollees. Another health plan said that in one part of its service area, no primary care providers will accept new Medicaid fee-for-service patients, but they will take Medicaid managed care enrollees of the health plan. The plan became aware of this difference when it received complaints from Medicaid enrollees whose caseworker (from the county office that determines eligibility) had told them no providers were available in that county; the caseworker was not aware that some of the providers were taking the HMO's patients. The health plan's ability to offer more providers than were available to fee-for-service Medicaid patients was due at least in part to the plan's higher payment rate.

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[1]These plans discussed specific examples of contracting with provider groups new to Medicaid and of issues that arose in dealing with providers new to Medicaid. Thus, it is a conservative figure--other plans may also have contracted with some providers new to Medicaid, though to a lesser extent.

Safety net providers' perspectives were consistent with the health plans' reports: in an overwhelming majority of communities we visited (18), the safety net providers reported that managed care had increased the number of primary care providers in the area that would serve Medicaid. Providers told us it was not the impact of a single health plan's provider network strategy that was increasing the availability of providers for the Medicaid population, but the combined effect of many health plans extending their provider networks along with providers' greater interest in Medicaid managed care due to shrinking financial opportunities for serving other populations. In one state, we heard that the state's and health plans' decision to credential and recognize nurse practitioners and physician assistants as primary care providers also has expanded the provider base available for Medicaid.

Managed care had also reportedly increased the number of specialists and hospitals available for Medicaid beneficiaries. Several plans (in different types of plans in different states) especially emphasized this, and providers tended to agree. One plan explained that payment is not the only issue--specialists are more willing to serve Medicaid when they are assured by the health plan's referral process that the member has had appropriate primary care and referral.

Though Medicaid managed care appears to have had a positive influence on the number of providers available for Medicaid beneficiaries--and we did not find evidence of widespread difficulties recruiting primary care providers--some isolated difficulties with recruitment remain. These are discussed further in Appendix B but are generally related to specific local circumstances or organizational difficulties, and in most cases the difficulties had not been severe enough to prevent full staffing of the facility. Further, we did not hear reports or observe any linkage between these remaining problems and managed care, except that in one area, an FQHC noted that it is now

more difficult to recruit nurse practitioners and physician assistants because of competition from managed care organizations.

Although managed care appears to have brought an influx of mainstream physicians available to the Medicaid population, it has not changed the supply of providers available to uninsured residents in most of the areas we visited. That is, the safety net providers we visited reported that they and other safety net providers continue to serve the uninsured residents of the area but that the providers that have been newly opening their practices to Medicaid have not been opening their practices to the uninsured. In the few cases where local health departments are (discontinuing primary care service because of managed care pressures, uninsured residents have one less provider option (See Chapter III).

One type of provider appears to be less available as a result of Medicaid managed care: the scattered "Medicaid mills" and transient storefront clinics that serve Medicaid: they are not being included in health plan provider networks because they do not meet the plans' credentialing standards, according to both plans and other providers. As one plan reported, "Managed care may mean the end of the storefront doc." Most respondents reported that few Medicaid mills and storefront clinics actually exist (e.g., one health plan said they constituted fewer than 5 percent of the Medicaid-serving physicians), but respondents mentioned that they are nevertheless present in many of the communities we visited. Health plans reportedly often identify providers as Medicaid mills during a preliminary office visit. Their utilization statistics, such as the number of visits per day, were reported to be extremely high, but no plan had specific criteria for identifying these providers... "You know them when you see them". The providers we spoke with could not tell us whether the number of "Medicaid mills" had decreased yet due to managed care because they are so difficult to track, opening one month and moving or closing the next.

2. Availability and Care Issues Related to New Medicaid Providers

Though managed care has increased the number of providers available to Medicaid beneficiaries, truly providing "access to care" for Medicaid enrollees is more complex than simply having the right number of providers available. Other important issues include (1) how much service to Medicaid the newly available providers are willing and able to give, (2) whether the newly available providers are located in areas with the most need for additional providers, and (3) whether, the newly available providers provide care in a culturally sensitive way that takes into account the barriers faced by low-income enrollees. Our study methodology did not allow us to assess these important issues well, since we did not interview physicians new to Medicaid or enrollees, and we did not review utilization data. However, the following discussion provides some insights on these issues based on our site visits with health plans and providers.

a. Amount of Service from Newly Available Providers

Many commercial-oriented providers that agree to see Medicaid enrollees set formal or informal limits on the number of Medicaid enrollees they will serve; we heard that it is easy for providers to create obstacles such as longer waits for appointments that discourage Medicaid enrollees from selecting them as a primary care provider. However, this is probably not restricting access significantly at present for several reasons. First, the commercial-based plans report that the vast majority of providers are not closing their practices to Medicaid before closing them to others. Second, in general, the plans report that providers have not been flooded by new Medicaid enrollees, despite some of their initial concerns. Third, the market conditions that led providers to decide to serve Medicaid more than in the past still exist, in that other payers are still implementing cost controls that threaten physicians' income and create more competition.

Though limits on the number of Medicaid enrollees accepted probably are not restricting access in most areas, one plan's experience suggests some areas may face greater problems than others. Before contracting with a new group, one plan asked for assurance from the providers (not their administrative representative) that they intended to serve a substantial number of Medicaid enrollees, because of past problems with enrollees signing up with a commercial-oriented primary care physician only to find they were not welcome.

b. Location of Newly Available Physicians

Many of the commercial-oriented primary care physicians that are newly accepting Medicaid enrollees are located in suburban and higher-income areas, plans acknowledged. Thus, their increased availability has a greater benefit for the relatively smaller number of Medicaid beneficiaries that live in those areas than in inner-city neighborhoods. Nevertheless, as noted above, many (18) of the 23 FQHC or other safety net providers said the number of primary care physicians available to Medicaid in their area had increased due to managed care. Thus, while the availability of primary care providers to Medicaid may have increased more in suburban than in inner-city areas, we observed some effect in the urban areas with high concentrations of Medicaid enrollees.

None of the three rural providers found that managed care had increased the supply of providers serving Medicaid in their areas, primarily because all the available providers were already serving Medicaid in those areas. In one rural community, the CHC said the financial benefits of managed care had enabled it to hire a physician. At the same time, another physician in the community failed to meet the plans' credentialing standards and thus had to stop seeing Medicaid patients. Thus, the area's net gain in the number of physicians was zero.

c. Culturally Competent Care from Newly Available Providers

Health plans and safety net providers expressed significant concern that the newly available providers might not be providing care in a culturally competent way that takes into account the barriers faced by low-income enrollees. The fears were (1) Medicaid enrollees with these providers might not get the care they need if, for example, providers assumed a level of environmental support and comfort at home that was not available or demanded that enrollees not bring children to the office, when there may not be an alternative care option, and (2) that new Medicaid-serving providers were not prepared for the difficulty of serving a low-income population and would turn away from such service once problems, such as frequent no-shows for appointments emerged. Neither we nor those we interviewed have enough information to assess how often these problems occur. However, access could be damaged by both suboptimal care and the potential for these providers to compete successfully in the short term for Medicaid enrollees--harvesting dollars needed to support providers with a long history and vital interest in serving Medicaid--only to turn away from them later.

Only one plan had a specific method for assisting providers new to Medicaid with the necessary adjustments. A second was developing a curriculum for teaching providers new to Medicaid about the challenges of serving this population and ways of approaching issues that may arise. Both were commercial-based plans seeking rapid expansion of their Medicaid business in competitive markets with a selective state RFP process. In the plan with a specific method for assistance in place, staff, mostly para-professionals, had been hired to assist providers with patient-specific issues. For example, if an enrollee does not show up for scheduled appointments, the provider's office notifies the designated plan staffer, and the plan arranges for transportation and a personal reminder prior to the next appointment. According to the plan, the benefits are that commercial-based providers are

more willing to serve additional Medicaid beneficiaries because of this support, providers are less likely to request that an individual be switched to another provider (that will predictably face the same problem), and the relationship between the patient and provider is strengthened.

The concerns of many health plans and providers about whether culturally sensitive care is being given by providers new to Medicaid are serious. However, the experience of one provider could suggest that beneficiaries who select a commercial-oriented provider accrue intangible 'benefits. This FQHC created a separate, new office downstairs from the FQHC that appeared to be a small private medical office. Named something different and marketed separately by the HMOs, the office was actually part of the FQHC and staffed by the same staff. Enrollees who began use to this new office, viewing it as a private practice, became very compliant, apparently feeling privileged to be in the office of a private physician. This gave the staff leverage for example, to say that if the patient is late again for an appointment, he/she will have to use the upstairs facility. Obviously, an office with compliant enrollees can be run more efficiently and may result in better care, if the compliance extends to better cooperation with treatment regimens or behavioral changes advised by the physician. The FQHC administrator is considering building a separate suite into a new site to duplicate this success.

B. CHANGES IN THE FLOW OF DOLLARS AND PATIENTS

Key Findings

- *Despite expanded options, patients did not change where they went for primary care as much as might be expected given the dramatic increase in Medicaid managed care since 1993 in the study areas.*

Key Findings (cont'd..)

- *Though Medicaid managed care changed how, when, and how much the safety net providers are paid, the changes were not bankrupting these providers or forcing most of them to reduce services to date.*

- *In the few cases where the services available were reduced at the safety net provider, access was not significantly reduced for community residents because alternatives existed.*

Managed care was increasing competition among providers for Medicaid enrollees and reducing financial protections for safety net providers, and in these and other Ways causing a change in the flow of dollars and patients in the underserved communities we visited. In theory, dramatic changes in financial or patient flows could bankrupt safety net providers or force reductions in their services that would diminish access for underserved communities. In fact, we did not find this happening during our study period.

1. Changes in the Flow of Dollars

Managed care has significantly changed how, when and how much many of the safety net providers are paid. Though in some cases payments to safety net providers were lower under Medicaid managed care (see Chapter III), the financial changes had not to date adversely affected the availability of services. Where revenue had declined, services and staffing were often maintained.

Most safety net providers were focused on becoming more efficient as discussed in Chapter III (by improving patient flow or productivity of physician staff), whether or not their revenue had

declined to date. Even in the four cases discussed in Chapter III where services had been reduced, access was not significantly reduced:

- One provider had to eliminate its pharmacy service, but other pharmacies were available throughout its service area though residents likely face higher out-of-pocket costs for using them.
- Two health departments had withdrawn from providing primary care, largely due to competition from other providers, but other providers were available nearby or were taking over at the same sites that had the primary care staff capacity to assume full responsibility for the health department users. In fact, the alternative sites offered more comprehensive primary care services.
- One provider had to reduce the level of effort it devoted to outreach services, but it did not eliminate outreach.

2. **Changes in the Flow of Patients**

Despite having greater options, patients in most areas did not change where they went for primary care as much as one might expect. Thus, some safety net providers failed to benefit from the increased volume of patients they had anticipated, while others were satisfied to retain the vast majority of their users despite increased competition for them. For example, one FQHC contracted with a new plan on less favorable terms than for its other managed care contract, in part because it hoped to receive additional patient volume through the plan. Instead, it gained no new users, but some existing enrollees switched from the plan that paid more favorably to the newly contracted plan. Another in a state that transitioned swiftly to a mandatory program found it retained 85 percent of its former patients and did not lose patient volume. Generally, FQHCs and other traditional Medicaid-serving providers were contracting with multiple health plans, and plans and providers reported that beneficiaries tended to choose a health plan based largely on being able to continue coming to health centers with which they were familiar.

There were a few exceptions to the general stability of patient care-seeking behavior in areas where competition was the most fierce and the provider was relatively ill-positioned to compete; in these areas the changes left the safety net provider with substantially fewer Medicaid enrollees.

C. CHANGES IN THE AVAILABILITY OF ENABLING SERVICES

Key Findings

- *The availability of enabling services in the communities we visited increased overall due to Medicaid managed care because plans were providing some enabling services and safety net providers had not discontinued or reduced them.*
- *Health plans' use of round-the-clock nurse advice lines and their requirements that contracted providers offer after-hours coverage are the access-related efforts that probably most improved access for Medicaid beneficiaries in managed care relative to those in fee-for-service. Many health plans had one or more other enabling services in place that also suggest improved access for enrollees, though the types of services varied widely.*

To date, the availability of enabling services in the communities we visited had increased overall due to Medicaid managed care, because health plans were providing some enabling services and safety net providers had not discontinued or reduced their enabling services.

Improved availability of 24-hour nurse advice lines and after-hours coverage required by health plans imply better access. A majority of the study plans required 24-hour coverage by their contracted providers and many of these tested compliance. We found a corresponding change in the way many of the providers we visited, especially FQHCs other than CHCs, offered this coverage, strongly suggesting improved access to primary care providers after hours.

Twenty-four hour nurse advice lines were another popular mechanism used by health plans to reduce emergency room use. At a minimum, nurse advice lines offer another point of first contact with

the health care system for a vulnerable population. Further, one plan explained that the nurse on the advice line can authorize transportation and over-the-counter drug purchases to be charged to the plan facilitating the enrollee's access to needed appointments and supplies in a friendly and convenient way. Another plan's nurse advice staff follows up with members who call. This year the staff will begin faxing all relevant information from calls to the member's primary care physician. We did not specifically ask about all the features of nurse advice lines in each plan, so these access-enhancing. features may be more common than we know.

Many plans emphasized one or two other enabling services, which varied by plan. Although many types of services were in place to a limited extent, most plans (nine of fhe 13) focused on one or two enabling services in addition to those discussed above. For example, transportation assistance was limited in many plans to bus tickets and taxi vouchers and in many cases transportation expenses had to be preauthorized by the plan. Consequently, the plans' transportation (assistance was rarely used, although transportation was viewed as an ongoing need in the community. Major transportation efforts were costly, though the cost varied dramatically among the four plans with this service in place (from $.85 to $2 to $3 per member per month). Where major transportation programs existed, they were reported to be heavily used. Thus, we conclude that health plans overall do not appear to be significantly addressing transportation needs in the communities they serve, though several study plans were exceptions to the rule.

Similarly, several plans had case management programs with dedicated staff that were heavily used up to their capacity (e.g., 300 active cases for a staff of 6 nurses), while other plans had mostly hospital-focused case management aimed at facilitating the patient's discharge to an appropriate, lower-cost setting. Most plans made welcome calls to new members, sometimes including health screening/outreach activities, but only 40 to 60 percent of enrollees had phones. As a result, we assume these calls had a limited effect on access, except in one plan, which followed up with in-

person visits when the enrollee could not be reached. Finally, most plans had some health education efforts and/or materials. Two plans' especially creative education efforts surely had some effect on the target groups, though we had no way to measure it. One had established multilingual audio taped health education messages on sensitive subjects like HIV/AIDS, two others had negotiated creatively to get diabetic education materials translated into Spanish after reviewing available materials that were already translated and finding them unsatisfactory.

Most safety net providers have thus far been able to sustain their enabling services as their managed care involvement has grown. Thus far, nearly all the safety net providers we visited--even those facing declining revenues under managed care--had managed to maintain the same level of enabling services. Only one of the visited health centers has had to cut back, reducing its outreach efforts. Although managed care contracts generally have not included financial support for enabling services, the overall financial support given to the provider is what determines its ability to provide enabling services at the same level--support that so far has been adequate for most providers.

In short, the enabling services available to Medicaid beneficiaries have increased, while those available to the uninsured and other users of the safety net providers remain about the same. This follows from the finding that health plans added services while in almost all cases safety net providers did not reduce them.

D. CHANGES IN ENROLLEES' UNDERSTANDING OF HOW TO ACCESS CARE

Key Findings

- *The new rules of Medicaid managed care have challenged enrollees to know how to access care, according to plans and providers.*
- *Confusion was especially prevalent during the months of transition to a mandatory managed care program, we were told.*

Many providers and plan staff agreed that the rules of Medicaid managed care had created a new challenge for enrollees seeking care to know how to access care.

1. State Medicaid Managed Care Program Implementation Process

A state's Medicaid managed care program implementation process was viewed as a key to access during transition to a mandatory program. In both the states we visited with mandatory programs, we heard that implementation caused some short-term access problems for some beneficiaries. One problem was getting enrollees assigned to an appropriate plan and provider if they failed to choose a plan or select a primary care provider at the appropriate time. We heard that enrollees frequently continued to visit their former provider, even after being assigned to a new one, placing the provider in the awkward position of turning away a patient or providing free care. Enrollees were usually allowed to switch plans, but formalizing a switch takes time (e.g., a month), and some enrollees do not switch (one center reports that 30 percent of its patients are rejected by the state for reimbursement because they have been assigned to other plans but continue to receive care at the center). Several providers we visited said they had had similar problems at least during the initial transition period to managed care. In such cases, health plans and their primary care providers reap financial windfalls since they are receiving capitation payments for enrollees who are getting free out-of-network care. Some health plans worked out temporary payment arrangements among themselves to try to correct payment inequities.

A second important issue, related to the first, was the need to clearly communicate to prospective enrollees which plan(s) to choose to stay with their usual provider. In at least one state, there was reportedly no easy way for prospective enrollees to find out which plans their usual provider is associated with. Guesswork sometimes proved faulty. For example, one FQHC believed that many enrollees had selected a Blue Cross plan thinking that the FQHC was a Blue Cross

provider. But since Blue Cross has many product lines--only one of which the FQHC participates in--these enrollees were mistaken; the Blue Cross logo visible in the FQHC did not mean that the provider was participating in the *Medicaid* Blue Cross managed care product. One plan pointed out that under door-to-door marketing that had been allowed prior to mandatory managed care, the marketing representative would discuss the health plan's provider locations with the beneficiary to avoid such misunderstandings.

In sum, all agree there had been substantial confusion that probably led to access problems for some enrollees for several months after the transition to mandatory managed care in the two mandatory programs we visited. However, plans and providers worked together--with providers sometimes providing free care--to minimize access problems. Thus we did not find specific examples where access was denied.

2. **Need for Better Education of Enrollees on Managed Care Rules**

Managed care has been confusing to some enrollees, according to staff we interviewed at five of the CHCs and three of the health plans. No one identified specific access problems, but the potential for such an effect is clear. The CHCs tended to blame health plans, for example, "plan reps don't explain provisions adequately--so the CHC winds up looking like the policeman, constantly telling people what they can and can't do under their plan." One plan, which often pays large provider groups and IPAs on a full-risk basis, explained that the issue of whose responsibility it is to educate patients and providers is a contentious one, because effective education is expensive. This plan believes education is the provider groups' responsibility. Thus, though there appears to be a consensus that a problem exists, plans and providers disagree about who is responsible for addressing it.

E. CHANGES UNDER WAY THAT MAY AFFECT ACCESS IN THE FUTIJRE

Key Findings

- *Several major changes in state Medicaid programs have the potential to affect access in the future, with most changes having more potential to restrict, rather than enhance, access and services. These changes include: more competitive contracting, decreases in capitation rates, enrollment of the disabled SSI/Medicaid population into managed care, and reduced financial protections for FQHCs.*

- *If plans shift additional risk and responsibility to providers in the near future, as some hope to do, this could have negative effects on access either by (1) shifting managed care contracts from independent FQHCs to larger provider groups or (2) causing FQHCs to have to manage more risk sooner than they are administratively capable of doing so.*

- *Safety net providers are pursuing managed care contracting and new alliances. The success of these strategies is important to FQHCs' future success under managed care.*

- *Many providers and some health plans expressed serious concern about whether Medicaid managed care would reduce access for the uninsured population in the future.*

Major changes were under way that--depending on when, how, and how much they occur--could threaten to erase the gains in service availability accrued to date. Below, we summarize respondents' reports and expectations about the most important changes and their potential impact, though neither the ultimate shape of the changes nor their impact are at all certain. Appendix E presents a more complete discussion of the changes under way in the study communities.

1. Major Shifts in State Medicaid Programs

The following major changes in state Medicaid programs have the potential to affect future access, with most having more potential to restrict access and services than to enhance them:

- ***More Competitive Contracting.*** We heard concerns for future access in three markets where options may decrease as a result of more competitive contracting, though not all those we interviewed agreed on the likely effect on access. In markets where a more competitive contracting process was being implemented together with a mandatory managed care program (6 of 10 markets), health plan options for beneficiaries were likely to continue to increase.

- ***Decreases in Capitation Rates.*** If rumored decreases in plan capitation rates are implemented, plans warned that access could be diminished as plans leave the Medicaid market or reduce enabling services and providers new to Medicaid withdraw because of lower rates.

- ***Enrollment of the Disabled Medicaid Population who Receive Supplemental Security Income (SSI) Benefits into Managed Care.*** Plans and providers we visited expressed a host of access and payment-related concerns about enrolling the disabled SSI/Medicaid population in managed care.

- ***Reduced Financial Protections for FQHCs.*** Providers were concerned about whether states would continue the current level of financial protections for FQHCs, and if not, whether FQHCs could survive and continue service to the uninsured in the long run.

2. Shifting of Additional Risk to Providers

In addition to changes in state Medicaid managed care programs, the shifting of additional financial risk to FQHCs in the near future could have negative effects on access. Five health plans, notably those with more experience serving the Medicaid population, expressed hope that they would soon be able to shift more risk and responsibility to providers. Such a shift could mean that plans change their contracting preferences to favor larger provider groups and smaller primary care groups affiliated with specialists and tertiary care facilities oversmaller primary care groups without strong affiliations. It could also result in a transfer of risk to groups without the ability to manage it

appropriately.' For example, one plan transferring full risk reported that a group new to Medicaid had developed aggressive medical management practices. As a result, plan staff have found themselves micromanaging individual member cases to ensure appropriate care is delivered.

As they take on more financial risk, a provider group's ability to serve a large volume of Medicaid enrollees and to effectively coordinate all their care will be crucial to its success. Smaller providers (including many of the safety net providers in the study) could affiliate with hospital systems and/or other specialty groups, though the trend at present is to affiliate with other like providers. Providers that are unable or unwilling to affiliate may face greater barriers to contracting with Medicaid-serving plans under this scenario, thus undermining their financial stability and potentially threatening access for groups who rely on them.

3. **Uncertain Success of Safety Net Providers' Managed Care Contracting Strategies and New Alliances**

Most of the health centers we visited were pursuing additional managed care contracts to protect against the loss of Medicaid patients as Medicaid managed care continues to expand. At the same time, some were also participating in FQHC-based health plans and creating formal provider networks of FQHCs.

The FQHC plans in the four markets where they existed were supporting the FQHCs with higher rates than other plans, but were facing stiff competition. Mandatory enrollment and associated default assignment rules for Medicaid managed care have hurt FQHC plans in two markets, while

'It is also possible that the Medicaid-focused plans, which tend to rely on the FQHCs and CHCs more than other plans, would like to transfer additional risk but will only do so as the FQHCs and CHCs position themselves better to manage such risk. Under this conservative assumption, we do not have reason to believe the shift would negatively affect access.

a third has been struggling with competitive bidding that threatens its foothold in several markets across the state.

Health centers in two markets were participating or planning formal provider networks comprised of FQHCs. Those in favor of the network approach see it as a way to achieve more favorable contract terms and to benefit from economies of scale through group purchasing and shared administrative functions. But one health center complained that contracts negotiated through their network are less favorable than those the health center negotiates on its own and that the network process takes much longer. Another health center is worried about being pushed into taking on too much risk and thinks its special mission and unique practice style may be harder to sustain if it forms an exclusive alliance with larger and more traditional health centers.

In sum, the long-term outlook for the FQHC-based plans and the provider networks that are forming is uncertain. Failure of these alliance strategies would certainly affect FQHCs' future viability.

4. **Concern for the Uninsured Population**

Many providers and some health plans expressed serious concern about whether Medicaid managed care would reduce access for the uninsured population in the future. Although most safety net providers have been able to sustain enabling services and uncompensated care thus far, they are worried that declining Medicaid managed care revenues and the loss of cost-based reimbursement protections will force cuts in these areas in the future. Although to date Medicaid managed care has resulted in increased enabling services overall and no decrease in safety net services, most viewed the Medicaid managed care program as designed to shift these services from the safety net providers to the health plans--a move the safety net providers fear would decrease access in their communities for both Medicaid enrollees and the uninsured populations that also rely on them.

Safety net providers also fear they will face an increased burden of uncompensated care from two sources. First, market pressures--in part due to Medicaid managed care--may be reducing the willingness of private providers to deliver uncompensated care. For example, one FQHC suspected that a neighboring hospital had made a subtle shift to reduce its uncompensated care burden: it would treat any uninsured patient who came to its emergency room, but now steers the patient to the FQHC rather than its own outpatient clinics for follow-up care. Second, welfare and other reforms are expected to increase the number of uninsured seeking care at FQHCs, as state and local programs for the uninsured are being cut back.

In sum, the FQHC program's cost-based reimbursement, current state protections for safety net providers, and/or reasonable rates from preferred managed care plans have allowed safety net providers to continue their traditional level of service to the uninsured thus far. The competition for Medicaid enrollees has even led to increases in availability of services for the uninsured in many areas as providers have added sites and expanded hours. However, the likelihood of a more difficult financial future, together with the prospect of an increased burden of uncompensated care, has forced many providers to think about difficult choices they may need to make to cut access-enhancing services, eliminate medical services such as on-site ancillary care, and/or limit the amount of care they provide to the uninsured.

V. CONCLUSIONS AND IMPLICATIONS

In this chapter, we summarize our conclusions, discuss to what extent we believe our findings can be generalized to other plans and markets and to the future, and outline the policy implications and future research priorities resulting from this work.

A. CONCLUSIONS

Overall, managed care strategies have had a more positive effect to date on the availability of primary care services in underserved communities than some have hypothesized. Commercial-based health plans tend to structure their provider networks and services differently from Medicaid-focused plans.

1. What strategies do health plans use to provide accessible services for Medicaid enrollees and what is the role of traditional Medicaid-serving providers such as Community Health Centers in these strategies?

Primary care provider network strategy. The strategies managed care plans use to provide Medicaid enrollees with access to primary care vary by type of plan. Commercial-based plans, especially those that integrate Medicaid enrollees into a provider network established for the commercial population, have contracted with many providers that have not previously served Medicaid, thus expanding the options available to Medicaid enrollees. While acknowledging the expanded access to primary care providers, some plans and providers we interviewed were concerned that new providers might not be prepared to help enrollees surmount the typical barriers to access faced by families in poverty such as the lack of transportation or child care. Few plans had specific programs advising providers new to Medicaid about these typical barriers and about strategies for dealing with them.

Health plans that were Medicaid-dominated relied on traditional Medicaid-serving providers such as CHCs and other FQHCs much more than other plans. We found two factors that have limited FQHCs' involvement in health plan networks to date: (1) limited interest by these providers in additional contracting, in part due to FQHCs' commitments to FQHC-owned plans in some areas, and (2) health plans' concerns about price/efficiency and the contracting process.

Provider standards and enabling services used by plans to enhance access. Plans used a variety of standards, monitoring mechanisms, and enabling services to enhance and ensure sufficient access to primary care for their enrollees. Both internal and external forces contributed to this. State requirements prompted some standards and supportive services, while others were initiated because of plans' views on Medicaid enrollees' special needs and how to best provide care within the capitation amounts provided by the state. In general, some of these standards or efforts were not monitored or enforced, and plans tended to focus on a smaller subset of services that they implemented with enthusiasm, going far beyond related state requirements.

Virtually all the plans we visited agreed that inner-city Medicaid enrollees have special needs, or at least special care-seeking issues, that most commercial enrollees do not have. Plans cited high emergency room use, high rates of no-shows for appointments, and a tendency to seek care without making an appointment as evidence of the need for special efforts to facilitate access to primary care. Transportation to appointments was the most commonly cited need.

Health plans whose origin and core mission was service to the Medicaid population generally provided more intensive supportive services, such as outreach and transportation than other plans. And mixed-model plans generally provided more intensive enabling services for enrollees of their

staff-model component, possibly due to payment incentives and/or the greater ease of providing some of these services in a small versus large geographic area.

2. What are the implications of different strategies for access to primary care for the Medicaid population and for the availability of primary care providers?

The different strategies of commercial-based and Medicaid-focused health plans have different implications for access to primary care. Commercial-based plans, along with broader market forces, have increased the supply of providers who are willing to care for Medicaid enrollees. Medicaid-focused plans work more closely with traditional Medicaid-serving providers such as CHCs and tend to offer a more intensive set of enabling services to enhance access to primary care. The data available for the study and the study methodology do not allow a quantitative analysis of provider supply and capacity of the safety net.

Overall, we found health plans' strategies imply many access benefits for Medicaid enrollees: increased provider options, additional care sites and expanded hours of operation for traditional Medicaid-serving providers prompted by competition and plan requirements, and in five (soon to be seven) of the 14 plans installation of 24-hour nurse advice lines offering enrollees another first point of contact with the care system. There were no reported negative effects on access for the uninsured, and some of the benefits that accrued to the Medicaid population--including increased number of safety net provider sites and extended hours of operation--also benefitted the uninsured who use the safety net providers.

However, providers and plans reported that Medicaid enrollees had difficulties accessing care under a system with more rules, particularly during the first months of a mandatory managed care program. Two common problems were (1) getting enrollees assigned to an appropriate plan and provider if they failed to select one and (2) clearly communicating to enrollees which plans to choose

to stay with their usual providers. The latter is particularly important because we heard that beneficiaries usually select a plan that will allow them to continue using a familiar provider.

Also, safety net providers and some plans expressed serious concern that shifts in state program policy and a more competitive environment would undermine access to care in the future, especially for uninsured residents.

3. **How do these strategies affect traditional Medicaid-serving providers such as CHCs?**

Of the two major types of safety net providers we visited, the health centers (CHCs and other FQHCs) were generally surviving well so far under managed care in varied types of managed care and Medicaid program environments, while the health departments providing primary care were re-thinking their role and two of the four were turning over primary care services to other providers. Managed care was reducing Medicaid financial protections and providing new incentives, and in a few cases in competitive markets, causing shifts in where enrollees get care.

For the most part, safety net providers were responding with administrative and operational changes that improved customer service and increased efficiency suggesting that during our study period managed care was not undermining access as had been feared, but was generally enhancing access at enrollees' traditional, familiar centers in addition to other locations. Even in the few cases where some services were reduced largely due to loss of revenue or patients from Medicaid managed care nearby, alternatives were available for Medicaid enrollees, and access for uninsured residents appeared unaffected though we could not definitively assess this during the study period.

B. GENERALIZABILITY

As with any study based on a case study approach, 'our results cannot be assumed to represent the experience of any other group of plans, providers, or communities. However, the range of plan

types, communities, and states in the study suggests that commons findings are not likely a fluke of our study. Perhaps least generalizable are our findings about (1) rural areas, because we visited only one rural-based plan and three rural providers, and (2) commercial-based plans, since we had few of the major, national managed care firms in our study. Also, our study's assessment of how safety net providers are faring under managed care did not include hospital outpatient departments, which play an important role in many of the study communities. Because our study involved communities, plans, and providers with especially high increases in Medicaid managed care over the past few years, most communities and providers should be experiencing lesser effects to date than those discussed here.

Can our findings be extrapolated to the future? No. Medicaid managed care and market changes underway suggest that access to primary care in the future could be different from--and may be worse than--what we have observed to date. If state Medicaid managed care programs continue to move to more competitive contracting processes and substantially lower capitation rates as expected, gains in service availability may be lost. Both plans and providers told us some of the enabling services were especially vulnerable to cutbacks, since these efforts are being provided above the required minimum level and direct financial support for them at the provider level is largely being eliminated under managed care. Access to care for the uninsured may be reduced as providers make increasingly difficult choices to remain financially viable with lower rates and greater competition. Lower rates would probably be passed on to providers, making it likely that commercial-oriented providers would again be less willing to serve Medicaid. Finally, the turmoil that likely impeded access during rapid transitions to mandatory managed care in two states we visited could be repeated in these or other states. This &as a significant concern, especially in one

of these states where a more competitive bidding strategy was poised to cause another round of dramatic changes in the health plan choices of enrollees.

C. POLICY IMPLICATIONS AND FUTURE RESEARCH

Policymakers have been concerned that the shift to managed care would mean impeded access to primary care and fewer enabling services for Medicaid beneficiaries, when in fact our findings suggest many benefits and few drawbacks for service availability *thus far*. However, the Medicaid program and pending market changes may well have different effects in the future. This suggests a need to monitor for changes in access or changes that could signal access problems. For example, plan and provider participation and interest in serving Medicaid under managed care is high at present, but could drop with pending rate reductions and more competitive managed care contracting processes. No state or national tracking systems are now in place for monitoring such changes.

Also, policymakers concerned about the effect of Medicaid managed care on safety net providers may be relieved at our findings that most CHCs and other FQHCs are making the difficult transition to managed care successfully thus far with courage, ingenuity, and hard work, though again their ability to maintain the same level of service in the face of increasing pressures is uncertain. Health plans were responding to state incentives to contract with CHCs and other FQHCs, although such incentives only go so far; the resulting contracts do not necessarily lead to a high volume of plan enrollees, we found.

To remain stable in an even more difficult future, CHCs and FQHCs will need continued support from the public sector. In particular, their networking strategies seem promising for addressing information system issues and increasing the number of enrollees and financial reserves under their influence, thus allowing them to better compete with organized provider groups and take on additional risk as markets move in that direction. Continued increases in provider competition,

"ratcheting down" of Medicaid rates and thus plan rates, and health plans' hopes of transferring more risk to contracted providers all suggest the need for ongoing monitoring of these providers' ability to continue providing the same level of services to uninsured as well as insured populations. Research on or monitoring of FQHCs' patient volume, services, and financial status :is one way to identify warning signals such as substantial shifts in enrollee volume away from these providers or elimination certain types of services. How much additional risk these providers assume from health plans--and under what conditions--is another important issue to track, since this could have a substantial effect on future access.

In addition to incentives to contract with FQHCs, other state program incentives and requirements related to access had prompted responses by health plans, though they too had limitations. Specifically, only a few plans monitored providers' compliance with standards for appointment availability, raising questions about the impact of the standards even though they were commonly in place and required by states. Also, plans questioned the usefulness of primary care provider capacity information (most often primary care provider-to-enrollee ratios) commonly required by states and actively used by two states for monitoring or contracting. In one case the usefulness was questioned because of plan doubts about how plans collected and self-reported the information, while in another the state's concern about a few particular providers that had reached the limit did not fit with the plan's sense of where access was a problem.

The plan efforts that likely benefitted access the most far exceeded related state requirements or were plans' own initiatives aimed at reducing emergency room visits or other hdgh-cost care patterns, which had the auxiliary effect of enhancing access to primary care providers. Thus, one way policymakers could help support broader implementation of and improvements in access-enhancing programs is by supporting evaluations of programs that work. For example, evidence that

outreach programs reduce emergency room visits, specialty care, or hospital costs, will persuade plans to implement them more widely and shield them from financial cutbacks.

Policymakers concerned with provider supply issues may be somewhat reassured by our finding that, at present, provider supply does not seem to be limiting the growth of managed care. Plans and safety net providers generally had not had problems recruiting sufficient providers, though a number of the safety net providers we visited relied on state and national loan repayment programs, the J-l visa program, residency programs, volunteer physicians, nurse practitioners, and physician assistants to maintain adequate supply.

The fact that plans and providers agreed that some Medicaid enrollees were confused about how to access care under managed care, especially during transitions to Medicaid managed care programs, suggests that work should continue to refine information provided to enrollees at the time of managed care enrollment. Who undertakes this work will vary by state, depending on how the state enrolls beneficiaries. In particular, the providers stressed that enrollees need to be able to easily identify the plans their familiar provider(s) are participating in and that the state-level and plan-level assignment processes when enrollees fail to select a plan or provider at the appropriate time could be improved. (These findings emerged from our discussions with plans and providers; the study was not designed to specifically explore consumer information issues.)

Further research addressing the effects of different plan strategies for access from the beneficiary perspective would complement our findings, which draw only on provider and health plan perspectives:

- Are the uninsured having more difficulty obtaining primary care in the more competitive environment or are they being shuffled around, and if so, to what types of providers?

- How do consumers rate the benefits of different types of primary care providers that reflect the different types of plans discussed here; for example, are they made comfortable and welcome for the most part in the offices of "private docs"? How severe or important are related problems?

- Are the sicker group of Medicaid managed care enrollees more satisfied with their care than those in fee-for-service programs (e.g., do they agree with plans that managed care has brought better availability of specialty care as well as primary care)?

- Are beneficiaries getting the enabling services that they need?

Other research could focus on "mining" other sources for quantitative information related to access from the beneficiary perspective, such as HEDIS indicators for the Medicaid population. In addition to research further examining the beneficiary's perspective, future work could look in more detail at the managed care strategies in rural areas and their effects on rural populations, and at the strategies commercial plans use to provide access for Medicaid beneficiaries and the factors that influence what strategies they use.

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AVAILABILITY OF PRIMARY CARE SERVICES UNDER MEDICAID MANAGED CARE: HOW 14 HEALTH PLANS PROVIDE ACCESS AND THE EXPERIENCE OF 23 SAFETY NET PROVIDERS AND THEIR COMMUNITIES

APPENDICES TO REPORT

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APPENDICES
(Report Bound Separately)

Appendix A	STUDY DESIGN AND METHODS IN MORE DETAIL
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Appendix A

Study Design and Methods in More Detail

STUDY DESIGN AND METHODS IN MORE DETAIL

1. Overview of Study Design

The study is primarily based on site visits to 14 health plans, and to 23 traditional Medicaid-serving providers located in the service areas of the health plans we visited. The following key features of the study design were intended to enhance our ability to respond to the research questions:

- ***Full-risk health plans with large Medicaid volume and large increases in volume.*** Health plans were selected as high-volume Medicaid plans serving urban, high-poverty areas and/or rural areas, that had increased the number of Medicaid enrollees substantially during 1993- 1995 (or, in the case of two new plans, by 1996). This type of plan, more than others, should be able to explain their strategies for expanding access to Medicaid and it is this type of plan that is having the most effect on access since large numbers of beneficiaries are enrolled and enrolling in these plans.

- ***Geographic link between selectedplans andproviders.*** Traditional Medicaid-serving providers were selected from among the inner-city and rural areas that the plan serves. This was intended to allow us to explore potential linkages between the health plan's strategy for providing access, and its effect on a particular underserved community.

- ***Bifurcated selection of contracted and non-contractedproviders. The*** original design called for us to visit, in each plan's service area, one traditional provider that had a contract with the visited plan, and another that did not have a contract. This was modified as the study proceeded, as described below.

- ***Among traditional Medicaid-serving providers, focus was on federally funded CHCs where feasible, but others included as well.*** Because of the importance of federally-funded community health centers to the infrastructure of underserved areas, and the special responsibilities of the Health Resources and Services Administration to those facilities, we selected CHCs on a preferred basis in the areas we visited.

- ***Geographic variation, but more than one plan per state in some states.*** The study aimed to select plans and communities that would provide geographic variation, but we also wanted to limit the number of states, knowing that state Medicaid programs are complex and we would get a better understanding of the influence of state policies in states where we visited multiple plans. Thus, in the end, we visited 14 plans in 8 states, as discussed more below.

We supplemented our visits to the individual health plans and providers with telephone interviews with senior executives of two national health plan organizations. Our objective was to (1) determine if such organizations had national-level strategies that would offer additional insights into our research questions, and (2) provide an additional level of comfort with findings to the extent these executives had similar observations across their many member plans. In addition to interviews, we attempted to quantify changes in primary care provider supply in six geographic areas within our study areas. This analysis was limited to six areas because of its exploratory nature and the expectation that despite our attempts, significant limitations would remain in the data.

2. **Selection of Participating Entities**

a. Health Plans

Confidentiality of the information sought was a key factor in obtaining health plans' participation in the study, and probably also contributed substantially to the quality and depth of information. Therefore, no plan names are provided and we have made every attempt to conceal information that could reveal the identify of a particular plan. Similarly, discussions with the national-level health plan executives were confidential.

Initial targeting of health plans. Medicaid enrollment totals by plan from the HCFA annual enrollment reports for 1993 and 1995 were used to identify plans with 20,000 or more Medicaid enrollees on June 30,1995, and which grew by at least 10,000 enrollees since June 1993.[1] Plans from Tennessee and Oregon were excluded from the list because the number of research studies on managed care in those states at the time suggested we would not get good cooperation and might be

'One that was on the borderline of meeting these criteria was included anyway because it was nearby, reducing potential travel cost, and with the rate of growth shown it probably now would meet the criteria. A second that did not quite meet the criteria was included because it was a rural-based HMO.

duplicating effort of other studies. The resulting list contained 47 plans with the following state distribution:

- 11 in NY
- 10 in CA
- 9 in WA
- 5 in PA
- 4 in FL
- 2 each in MI, OH, and MD
- 1 each in VA and CO

We initially targeted sixteen of these plans, located in six states. From the information available from HCFA enrollment report and the GHAA Industry Directory, we judgmentally selected plans that as a group had the following characteristics:

- Six and possibly as many as eight appeared to serve some rural area, though only one is rural-based.
- Eight appear to be all or nearly all Medicaid, with three others having between 22 and 29 percent of total enrollment accounted for by Medicaid enrollees, including some large, national HMO firms.
- Together, the plans include nearly a million Medicaid enrollees (922,080), and doubled their enrollment during 1993-l 995 (487,885).
- Half (eight) were new to Medicaid since 1993--this reflects but may somewhat understate the extent to which the general pattern of growth in enrollment has been in plans new to Medicaid; we deliberately selected at least one and preferably two plans in each state cluster, as well as other scattered plans that were *not* new to Medicaid.
- Maps showing C/MHC locations suggest all the plans have at least one CHC in their service area.

Substitutions in health plan selection. Ten of the 16 targeted plans agreed (eventually) to participate in our study. Substitutions were made for the other plans, keeping as close to our original criteria as possible. Generally, we were successful in getting plans that, as a group, had similar characteristics to those originally targeted, and we were able to visit all the targeted market areas except for one. Of note, none of the originally targeted plans were newly formed plans, although some were new to Medicaid. As we substituted plans, we decided to visit two newly formed plans that had Medicaid enrollment levels near (in one case) or above 20,000, partly as a practical matter to obtain cooperation and complete our visits, and partly because we thought new plans might have different access strategies and thus contribute to our understanding of the research questions. The characteristics of the plans that ultimately participated are described below in Section D.

b. Selection of Traditional Medicaid-Serving Providers

Because of the desired linkage between selected health plans' service areas and the traditional Medicaid-serving providers we would visit, we selected and solicited participation from the CHCs and other providers only after obtaining cooperation and a visit date for a health plan. The providers were selected judgmentally in each area, using the following rough guidelines:

- Where feasible, we selected one provider in each service area (preferably a CHC) that was contracted with the plan and served a substantial number of plan enrollees, and a second that was not participating in managed care. Although originally the study design called for selecting one contracted with the plan and one not contracted with the plan, the high level of competition among plans made participation in managed care generally the more **relevant issue.**
- We wanted to include visits to at least a few rural providers; therefore, we seized this opportunity when selecting among options in some areas.
- Where we heard that a safety net provider was discontinuing primary services because of Medicaid managed care in an area served by a study plan, we visited that provider since we viewed understanding this as key to assessing whether access was changing

for that community; this occurred twice and both times the provider was a local health department.

In reality, we did not always have much information in advance about the potential Medicaid-serving providers from which to select, so that in some areas, our choice of providers could be considered random from among the relevant listings in the Primary Care Programs Directory, issued by the Bureau of Primary Care at HRSA. Section D below describes the characteristics of the group that participated.

3. Site Visit Approach

Site visits were conducted during April through December 1996. In any study based on multiple site visits, consistency of the research across sites and number and types of staff involved are key issues. The project director and one other experienced research staff first visited two sites together, then one or the other led each of the remaining visits. The third core team member and report author also participated in a majority of the visits. Our general approach to the site visits was to approach the health plan first, requesting ½ day of time from plan executives responsible for making the decisions about how the health plan builds its provider network and responsible for other services the plan may have that help to provide access to primary care for Medicaid enrollees. Once we obtained agreement, we approached the executive directors of two traditional Medicaid-serving providers in its service area and asked for two to three hours of time from them and any other persons key to exploring the study topics (often the 'medical director and CFO participated and sometimes others). Thus, each site's schedule typically consisted of 1 ½ days of interviews on site.

Semi-structured protocols were used for health plans and the traditional Medicaid-serving providers as follows. The health plan protocol contained the following sections for each plan, with guideline-type questions and probes within each section:

- Overview of the plan (organization and history)
- Background on Medicaid service
- Provider network in inner-city and rural areas
- Gatekeeping policies and coordination of care
- Role of CHCs in assisting plan in providing accessible and appropriate care
- Special services or steps taken to enhance access
- Conclusion

For mixed-model plans, the protocol differed in that we asked additional questions on how the different components functioned together, and how they differed or were similar in their access strategies on the above topics. To keep the interviews to a reasonable length, we focused on the component of the mixed model plan with the most growth, then asked brief summary questions about the other component.

The protocol for the traditional Medicaid-serving providers differed for providers that were and were not contracted with the study plan, but covered similar topics except as noted:

- Background
- Managed care experience
- Specific managed care plan information (about the study plan) (omitted for non-contracted plans)
- Utilization and financing trends

- Conclusions

Also, we obtained BCRR data when available and a checklist of services provided in advance of the visit; these data were discussed on site in addition to following the above-mentioned interview protocol, except in a few cases where time did not permit.

Nearly always, two project team members were present at the interviews, working as a team to follow up on points of interest and jointly create an enhanced understanding of each site. The interviews were documented in detail following the visit, according to a common format to facilitate comparisons across sites.

4. Analysis

4

We analyzed the study information primarily using qualitative analysis techniques, though some descriptive quantitative analysis was also used to analyze trends in patient care volume and revenue of CHCs, and to analyze changes in provider supply in six focus areas. Our approach to analyzing each of the research questions is as follows.

a. What strategies do health plans use to generate access to primary care for the Medicaid population? What role do traditional Medicaid-serving providers such as community health centers (CHCs) play in these strategies?

The health plan is the unit of analysis for describing health plan strategies that may affect access. For the three mixed-model plans, we focused on the component of the plan with the most growth (the network side, in all three cases), but noted differences where they occurred. We discussed strategies the plan used to build its primary care provider network throughout its service area, but focused most on areas where it expanded since 1993, and with very large plans we found it necessary to define a city or rural area of particular interest in order to select providers for visits and to reach a community-level understanding of that area. Though we asked plans how their strategies differed for inner-city and

rural areas versus others, most plans did not have a distinct strategy for these areas so that our analysis is really focused on all the areas where the health plan expanded--which included but were not only inner-city and rural areas.

Because a health plan's access strategy has multiple, dissimilar components, we both analyzed each component separately, and drew the information together again to'summarize the types of plans in our study with different overall strategies. The components we analyzed are (1) the plan's strategy for building its provider network, (2) any access-related requirements the plan imposes on providers (such as appointment availability standards or maximum panel sizes), and any assistance the plan has given to providers related to access, and (3) any supportive services the plan may provide to enhance enrollees' access to primary care (such as transportation, outreach, health education).

To analyze the role of government policies and program features in shaping plan strategies and affecting access, we analyzed information by grouping plans and providers within each state or Medicaid program area where we had visited more than one, because Medicaid program policies are usually consistent across states though in one of our study states, they differed by county. So, for example, we looked for similarities of experience with the transition to mandatory managed care between the two providers in one state, and separately for the three providers in another state. We also looked for patterns by type of program, in terms of whether the program was mandatory or voluntary.

To assess the role of traditional Medicaid-serving providers in health plan strategies, we primarily relied on the health plan as the unit of analysis because information from the health plans was the most comprehensive. That is, each health plan told us about the role of all of **the** CHCs, FQHC look-alikes, and other traditional Medicaid-serving providers in its provider network--why they had contracts with some and not others, how the providers differed from one another, to what extent they had plan enrollees versus contracts but few enrollees, etc. In contrast, our provider-level information pertained

only to the two providers we visited. We reviewed to ensure the two sets of information were roughly consistent, however.

b. What are the implications of different strategies for overall access to primary care for the Medicaid population? for the availability of primary care providers? for the availability of culturally competent or minority primary care personnel? for the level of available enabling services and availability of providers specially trained to treat the Medicaid population?

To assess how health plan strategies for providing access to care were affecting access, we discuss and synthesize information from several different sources and analyses, with different units of analysis. This general technique of synthesizing across different types of sources is known as "triangulation." The following sources and types of information were used.

Health plans. We analyzed information from the health plans on how they perceived that their method for building a primary care provider network affected access, and identified any specific examples they could give of the stated effect. We were open to using different types of examples, for example, a plan could describe having recently contracted with a medical group to serve Medicaid, where that group had not served Medicaid in the past. Or, it could explain that before the state's Medicaid managed care program, X percent of providers in its core service area had served Medicaid, and now, Y do, and it believes this is clearly due to managed care having higher rates. Thus, we reviewed a collection of examples and information of different kinds for whether, taken together, they suggested a change in access.

To assess the likely effect of plans' access-related requirements on providers on access, we discussed with them their perception of any effect, and whether they had monitored effects or had other information that might suggest an effect, for example, if problems found before the requirement had abated.

To analyze the likely effect of supportive services provided by plans on access, we discussed with plans at least briefly whether and how they implemented a list of pre-defined types of supportive services and access-related requirements for providers. The list of types was based on the prior study for HRSA which gave us a general sense for the types of efforts in place. (We asked plans if there were other efforts we had missed, but they generally did not add others.) Using this information, we conducted two types of analysis.

For one analysis, we used the program as the unit of analysis, drawing on the specific information provided by each health plan on programs of that type that were in place, to address the question, does this type of program appear to be having an affect on access across many plans? Information such as use of the program, level of effort devoted to it, how the program was structured to be logically related to the needs of the plan's population, were considered in this assessment. We did not have similar levels of depth for each program at each health plan; rather, we collected more information about the programs the health plan emphasized and said were very important to increasing access. Patterns that were reported were ones that stood out quite clearly; thus, we have a conservative bias in that we may have underestimated the effect of some types of programs on access, though we think this is unlikely given the relevant discussions and reactions from the traditional Medicaid-serving providers about these types of programs.

For another analysis of supportive services, we used the health plan as the unit of analysis to address the question, do different types of health plans tend to use different levels/types of supportive services? For this, we coded health plan programs of each type for each plan, judgmentally giving the plan a "+" if it had placed special emphasis on a program or had a creative or well-used program in place, a checkmark if they had that type of program in place, and an indicator for no program if they did not have such an effort in place. We then counted the number of programs in place for different

types of plans, and gave a summary assessment of each plan ("higher" or "lower" support services) based on the number of checkmarks and "+'s" in total for that plan.

Traditional Medicaid-Serving Providers. We analyzed information from the traditional Medicaid-serving providers about access-related changes that had occurred at their facility and in their community since 1993, and their perception of the causes of the changes. The changes we discussed that related to access included probing about the number of Medicaid-serving providers in the community, providers served the uninsured population, changes in staffing and supportive services available from the visited provider and others, remaining access needs in the community, and the financial situation of the provider as a possible indication of future outlook. We discussed operational responses of the provider to Medicaid managed care, so as part of this should have obtained information on any changes the provider made in response to plan requirements related to access. This gave us an indication of whether plans' requirements were having an effect at the provider level, thus potentially affecting access for enrollees.

Directories of Providers and BCRR Data Supplemented by Telephone Calls to Providers in Six Areas with Especially High Growth in Medicaid Managed Care. Although our analysis of how health plan access strategies have affected access was mainly qualitative, we attempted to quantify provider supply changes to the extent feasible in six areas that we visited with especially high growth in Medicaid managed care.

To select six areas of focus for this analysis, we first identified broadly-defined areas within the service areas of the plans we visited that appeared to be or were mentioned as areas with particularly high growth in Medicaid managed care since 1993. (Note that while our criteria for plan selection ensured the *plan* had high growth in enrollment and was located in a state with high growth, there is not a one-to-one match between plans that grow in enrollment and an area's growth in enrollment.) We reviewed data from Interstudy for those MSAs to ensure the data suggest high growth. Second,

among those areas on the list, we preferred smaller areas within these broader areas that are ones that we visited, where those smaller areas were reported to have high growth in Medicaid managed care and a high concentration of Medicaid residents in the area. Selecting a relatively small area is consistent with our proposal and keeps the task feasible. Following this procedure, six geographic areas were selected for focus: three were small sub-parts of large cities, two were smaller cities, and one was a large, very rural county.

Our strategy for estimating provider supply changes involved four components in each area. First, data for the CHCs we visited on primary care staffing levels and changes since 1993 were verified by the Centers. The Centers also listed for us other Medicaid-serving providers located in their service areas, and in our zip-code groupings (which were often larger than their service area) to the extent they could and gave us contact information for follow-up. The contacts were asked about the number of primary care physicians, nurse practitioners, physician assistants at those locations, how many of each worked part-time versus full-time, and how the number had changed since 1993.

Second, hospitals located in or just outside the areas of interest were identified through the American Hospital Association directory and by asking others we spoke with in the area whether there was a key hospital just outside the area. The hospitals were asked to provide the number of full-time-equivalent primary care physician staff (residents separate if possible), nurse practitioner and physician assistant staff working in their outpatient departments, and to identify and if possible provide information on other hospital-owned clinics not located with the hospital. They were asked how these figures changed since 1993.

Third, we identified medical group practices located in the zip code areas of interest. The Big Book and the MetroNet search mechanism for the American Business Information database were

used along with AMA data to identify medical groups in the zip code areas. This strategy evolved as follows. We first obtained data from the American Medical Association listing primary care physicians in the zip code areas of interest for 1993 and most current (December 1996). This was the only source of information that we could find that listed physicians by primary care specialty, provided phone numbers, and could provide historical information from 1993. However, we found that the AMA physician listings included many home addresses and phone numbers for the physicians (we estimate at least a quarter of the listings for one area are home addresses based on explicit apartment numbers being listed and a few test phone calls). This was problematic for our study since we were interested in the number practicing in our defined location.

So, we searched for other sources of information on physician location by zip code. We found two other sources of information, MetroNet and the BigBook, though they did not separate primary care from other types of physicians. By comparing information for one zip code, we determined that some physicians and groups were unique to the MetroNet, and others to the BigBook, and so decided that neither could be assumed a more complete source for our purposes. We also compared these sources more thoroughly for one zip code in each of three markets for the benefit of any future researchers considering these sources. We identified the number of listings in each market which appeared from their name to be medical groups and were not obviously specialty groups. Table A. 1 provides the comparison, and shows that the agreement among sources varied dramatically by market. This large difference among sources is discouraging for those attempting to find a simple way of identifying primary care practices in an area.

Group practices (3 or more physicians) were contacted and asked how many primary care physicians, nurse practitioners, and physician assistants worked at that location, to what extent these were full-time or part-time employees, and how this had changed since 1993.

TABLE A. 1

AGREEMENT AMONG SOURCES
Percent of Medical Group Listings in Each Area

	Area 1	Area 2	Area 3
Full Agreement (Big Book, MetroNet, AMA)	4%	5%	5%
Big Book and MetroNet	29	20	36
AMA and either Big Book or MetroNet	3	3	2
Unique to One Source			
Big Book	13	14	12
Metro Net	33	19	16
AMA	18	39	29
Total Listings	100%	100%	100%

For the fourth component of this analysis, we counted the number of individuals not contacted under one of the other components, from the American Medical Association's listing of primary care physicians for 1993 and 1996.

We analyzed our results area by area, creating tables that summarized the results of each component (CHCs, hospitals, medical groups, individuals) separately.

c. How do these strategies affect traditional Medicaid-serving providers in a community? CHCs/FQHCs that become part of an HMO network? CHCs/FQHCs that do not become part of an HMO network? other traditional community providers?

To assess the effect of health plan access strategies on traditional Medicaid-serving providers, we performed analysis of site visit information and BCRR data.

Information from site visit interviews. We synthesized the site visit interview information to describe the responses of the traditional Medicaid-serving providers to Medicaid managed care generally, and their experience with the health plan studied, if the provider was contracted with that plan. We asked for examples of how access had changed, and how operations or finances had been affected by managed care, to get beyond general responses on key areas of interest.

We also identified health centers that have fared well and those that are struggling and more vulnerable, and compared their characteristics. Centers that were struggling and more vulnerable and those that were faring well were identified based on a combination of qualitative and qualitative information. First we examined trends since 1993 in the following: total revenue, revenue from insurers, net income under managed care, patient volume, and volume of Medicaid patients, primary care staff FTEs. and the number and size of clinic sites. Then we incorporated insights from the site visits to finalize the lists of stable versus more vulnerable providers (this did not result in any new

providers being added to the list, but two were removed). We analyzed this separately for health departments, because of the major organizational differences between the two types of providers.

BCRR Data. Bureau Common Reporting Requirements data were used for 1993 and 1996 to identify trends in patient volume, revenues, and staffing at the centers. In general, we obtained this information from HRSA prior to the site visit and discussed the data with the administrator or CFO at the Center on our visit.

5. **Overview Tables Showing Characteristics of Visited Sites**

Tables A.2 through A.4, which follow, provide more complete descriptive information about our visited sites than do the tables found in Chapter I.

TABLE A.2

CHARACTERISTICS OF HEALTH PLANS STUDIED

	Number of Health Plans
A. Plan Type and Size	
Model	
Network /IPA	11
Group/Staff	0
Mixed Model	3
Tax status	
Nonprofit	7
For-profit	7
Ownership	
National Managed Care Company	0
Regional Managed Care Company	1
Commercial Insurer or Blue Cross Blue Shield	3
Independent and Other	10
Total Enrollment	
< 50,000	4
50-99,999	3
100-249,999	5
250,000 or more	2
B. Medicaid Service	
Years Serving Medicaid in area	
o-1	2
2-4	2
5-9	2
10 or more	8
Medicaid Enrollment	
< 20,000 enrollees	2
21-40,000 enrollees	3
41-65,000 enrollees	4
> 65,000 enrollees	5
Medicaid as a Proportion of Total Enrollment	
< 25 percent	4
25-49 percent	1
50-74 percent	2
75-89 percent	2
90 percent+	5

TABLE A.3

OVERVIEW OF TRADITIONAL MEDICAID
PROVIDERS VISITED

Characteristics	Number of Study Providers: Community-Based Health Centers N=19	Number of Study Providers: Health Departments N=4
Type of Provider		
CHC	13	0
Other FQHC	4	1
Other (rural health clinic, municipal clinic, non-FQHC health departments)	2	3
Service Area		
Large Urban	11	3
Small Urban	5	1
Rural	3	0
User Volume[a]		
Under 5,000	3	2
5,000 to 10,000	4	0
10,000 to 20,000	4	1
More than 20,000	7	1
unknown	1	0
Proportion of 1995 Revenue from Medicaid		
Under 30 percent	3	1
30-50 percent	10	2
More than 50 percent	5	0
unknown	1	1
Grants as a Proportion of Total Revenue (1995)		
Under 30 percent	2	0
30-50 percent	9	1
50 percent or more	7	3
unknown	1	0
Number of Managed Care Enrollees (1995)		
None	5	1
1-2499	5	1
2500-5,000	4	1
More than 5,000	4	1
unknown	1	0

Characteristics	Number of Study Providers: Community-Based Health Centers N=19	Number of Study Providers: Health Departments N=4
Proportion of Users in Medicaid Managed Care		
Less than 1 percent	3	2
1 9 percent	0	0
1 I-35 percent	6	0
More than 35 percent	5	0
Unknown	5	2
Relationship with FQHC Plans or Networks		
Affiliated with an FQHC plan	6	1
Part of an FQHC network	4	0
No involvement	9	3
Capitation-Current Contracts		
Primary Care Only	14	2
Primary and Specialty Care	2	0
Not Applicable	3	2
Financial Incentives for Specialty or Hospital Care Current Contracts		
Surplus sharing	5	1
Surplus and loss sharing	2	0
None	11	1
Not Applicable	2	1
Enrollment in Medicaid Managed Care to Date		
Voluntary	11	2
Mandatory	8	2
FQHC Cost-related Reimbursement under Managed Care to Date		
Available	8	1
Not available	11	3

[a]Information collected from BCRR and on-site interviews.

TABLE A-4

CHARACTERISTICS OF MARKETS STUDIED AND THE MEDICAID MANAGED CARE PROGRAMS OPERATING THEM

	Number of Markets (out of 10)
A. Geographic Characteristics	
Geographic Regions	
Northeast	
Midwest	
South	
West	
Setting"	
Large Urban	
Small Urban	
Urban and Rural	
Rural	
B. Medicaid and Uninsured Populations	
Medicaid as proportion of total population[b,1]	
(National average: 13%)	
Less than 10%	
10-15%	
16-25%	
Proportion < 65 uninsured	
(National average: 17%)'	
Less than 10%	
10 - 15%	
16 - 24%	
25 - 35%	
C. Managed Care	
HMO market penetration[2]	
(National average: 15%)	
Less than 15 %	
15-20%	
21-30%	
Greater than 35%	

TABLE A.4 (continued. .)

	Number of Markets (out of 10)
D. Medicaid Managed Care	
Groups Currently Enrolled	
All Voluntary	1
Voluntary moving to mandatory	5
AFDC mandatory and SSI voluntary	1
AFDC mandatory, with SSI moving to mandatory	3
State Selection of Contractors	
Process	
Contract with a limited number, using an RFP process	4
Contract with all qualified providers, using certification	6
Criteria	
Select on price only	0
Select on technical components	6
Select on a combination of price and technical	4
Traditional Provider/FQHC Protections	
None	2
Incentive in bidding process	8
Enhanced payment	
Through state	2
Through plan	2
State provisions for Medicaid-only plans	
Yes	8
NO	2

SOURCES: 'Employee Benefit Research Institute. "Sources of Health Insurance and Characteristics of the Uninsured." Analysis of the 1995 Current Population Survey. Washington, DC: Employee Benefit Research Institute.

[2]InterStudy, Inc. The InterStudy Competitive Edge 5.2. St Paul MN: InterStudy, Inc., 1995.

"Plan may serve more than one market area. Characteristics described here refer to the market studied.

[b]Aid for Dependent Children (AFDC) and SSI, not medically needy.

Appendix B

Quantitative Analysis of Provider Supply in Six Communities

QUANTITATIVE ANALYSIS OF PROVIDER SUPPLY IN SIX COMMUNITIES

Our quantitative analysis of provider supply in six communities was inconclusive in terms of the trend in number of primary care providers in the communities since 1993, due to data limitations as well as contrary indications from different data sources which vary in reliability. This appendix explains what trends appeared from each of the different data sources and analyses.

Safety net providers we visited increasedprimary care staff in four of the six areas. Table B. 1 shows that in four of the six areas, the community health centers and other safety net providers we visited experienced an increase in the number of FTE primary care staff, while visited safety net providers in the two mid-west communities showed a decrease.

Hospital outpatient departments are key providers to Medicaid in the six areas, but could not easily provide us information on change in their number of primary care providers. In addition to providing us with their own trends in primary care staff, we asked the sites to provide us with the names of other providers in their areas that were substantial providers of primary care to Medicaid beneficiaries, and they most often listed hospital outpatient departments. We attempted to contact the hospital outpatient departments mentioned to clarify their role and how it has changed since 1993, however, they were not adequately responsive to allow us to draw conclusions from this. However, it was clear that the named hospitals employed significant numbers of primary care providers in the areas of the safety net providers, for example, the major hospital in one community employs 107 primary care physicians in its primary care center, and the two hospitals in a second community employ more than 50 primary care physicians (the two CHCs in this area, which we visited, combined employ about 21 FTEs of primary care providers). For the only three of these hospitals that were willing to tell us how the number of primary care providers there had changed

TABLE B. 1

PRIMARY CARE PROVIDER STAFFING IN VISITED SAFETY NET PROVIDERS IN SIX AREAS 1993-1996

Area	FTE Primary Care Physician Staff 1996	FTE Nurse Practitioner, Physician Assistant and Certified Nurse Midwife Staff 1996	Total Primary Care FTEs 1996	Change in Total FTEs Since 1993
1 (Large Urban)	10.35	3.3	13.65	Increase
2 (Rural)	3	2	5	+1 (MD)
3 (Large Urban)	33.5	11.9	45.4	-2.1
4 (Smaller Urban)	15.7 (1995)	5.4	21.1	Increase
5 (Smaller Urban)	3.4	2.4	1	-7
6 (Large Urban)	21.3	2.4	23.7	+3.1

SOURCE: Interviews with site administrators on site, and/or BCRR data for 1993 and 1995. Two visited sites for whom we did not have BCRR were not able to provide 1993 data, but they said their staffing had increased, which clearly indicates an increase across sites for areas 1 and 3, though it does not tell us the amount of increase or decrease.

since 1993, the numbers showed stability or increases (+3 FTEs in one community, +6 primary care providers in another, the same or a small increase in the third).

Trends in individual primary care physicians from AMA runs counter to other information and data appear insufficientfor this type of analysis. Since our interest was in the total supply of primary care providers to the areas of focus, we searched for other ways to identify medical groups and individuals in the defined areas and how the number of these providers had changed since 1993. We first obtained and examined data from the American Medical Association (AMA) for 1993 and 1996, which listed individual primary care physicians by zip code for our areas of interest. The results show a relatively large decrease in each area of interest, although this trend runs counter to our other information, including the observations of the staff at safety net providers whom we interviewed about provider supply in the community.

We believe the decreases in number of primary care providers shown by the AMA data are probably due to data limitations, and thus do not present the quantitative results here. Specifically, the AMA data appear to contain a large number (e.g., one-fourth) of home addresses for physicians; because the data are by individual physician and do not list a medical group or hospital affiliation, there is no way to use most of these data to contact major providers in the areas to confirm and update the information.

Medical groups contributed substantially to primary care provider supply in the focus areas. To identify other medical groups in the areas of interest, we searched two databases, called "The Big Book," and "MetroNet."[1] Each of these allowed us to list medical groups and independent individual physicians by zip code for our areas of interest, but they did not specifically distinguish

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'We used both databases rather than one or the other, because the two sources agreed on only 20 to 36 percent of the medical group listings in the three areas examined for agreement of sources--that is, many listings were unique to one or the other.

groups and individuals providing primary care from others. However, we could eliminate many specialty groups by their names (e.g., Radiology Associates). Recognizing the inherent limitations of the analysis and to keep our task feasible, we focused on groups of physicians that were not obviously specialty groups, either identified by a group name, or where 3 or more physicians were listed with the same address. Table B.2 shows the number of medical groups identified and the number that provided some information about their primary care staffmg and/or trend.

We were more successful in learning that these other groups together contributed large numbers of primary care providers to the provider supply in the area than we were determining the extent of a trend since 1993. For example, we found that the groups we identified in each of the five urban areas of focus (ranging from 11 groups in one area to 41 in another) employed between 55 and 113 primary care physicians in each area, and between 8 and 87 nurse practitioners, physician assistants, and nurse midwives in each area. Also, larger primary care groups were common in three of our five urban focus areas, where the average size was 5 or 6 physicians versus only 2 or 3 in the other two areas. Many groups on the listings proved to have only one or two physicians, or physicians at the same address proved to be independent.

Trend information from medical groups quite limited but shows relative stability of numbers in three areas and probably some increases in the number of primary care staff of groups in two of these areas. The trend information was more limited. In only three of the five areas were more than half the groups were willing to discuss the change in number of primary care providers. For those three areas, ***73, 82,*** and ***88*** percent of the responding groups, respectively, reported no change in the number of primary care providers at their location since 1993.[2]

'There were 11, 34 and 16 responding groups, respectively.

TABLE B.2

NUMBER OF MEDICAL GROUPS IDENTIFIED IN ZIP CODE AREAS AND THEIR RESPONSIVENESS

Area	Total Medicaid Groups Identified'	No Answer or Wrong Number	Not Primary Care	Answering Service	Non-Responsive	Groups That Provided at least Some Information
1	37	5	7	3	2	20
2	61	4	3	5	8	41
3	50	10	4	7	11	18
4	19	8	0	0	0	11
5.	37	9	13	0	1	13

'Includes all listings where more than 3 physicians were listed and who did not have a name that obviously indicated a specialty group.

Two of these areas had only one group reporting a decrease, and multiple groups reporting increases. Table B.l also showed that the safety net providers we visited had increases in their primary care staff as well (not counted in the groups analysis). And, information on one of two key hospitals in one of these areas shows an increase in primary care staff. No information was available on the other hospital or hospitals in the second area.

In contrast, two groups in the third area reported decreases and no groups reported increases.' Also, the safety net providers we visited there experienced a slight decline in number of staff. We have no information on the trend at the hospital, however, which is a major provider of primary care that could more than make up for this change if its primary care staff had increased. From our site visit we learned the following about this area:

The area's building stock and infrastructure appear "run down," in places resembling a war zone, reflecting persistent high unemployment and poverty. The physicians who practice in the area are reported to be relatively advanced in age, so that the pace of replacement has been slower than the pace of retirement, we were told. In the future, however, the supply of primary care providers may increase, since the number of staff at the CHC has been limited by space, and new space is in the planning stages. The CHC has not to date had problems recruiting enough providers, largely due to providers made available through the J-l visa program.

Our information on the extent of changes in primary care providers is too limited to report, though most groups that reported a change and could quantify it reported a small change of one or two providers. Only one group across all the areas told us it had a sizable decline in primary care staff--a group focused on maternal and infant care whose funding had changed and where births had declined, resulting in a loss of between 5 and 15 prim& care physicians since **1993 .**

Appendix C

Types of Enabling Services Being Implemented by Health Plans

TYPES OF ENABLING SERVICES BEING IMPLEMENTED BY HEALTH PLANS AND EXAMPLES OF INNOVATIVE, INTENSIVE APPROACHES

A. TYPES OF ENABLING SERVICES BEING IMPLEMENTED

We found plans had implemented the following 8 types of enabling services to help enhance access to primary care for the Medicaid population.

Transportation for non-emergent care. Two states had specific statewide transportation policies/programs in place. In one, the state had a transportation program that supplements the capitated Medicaid managed care program, so that health plans in that state did not provide transportation for members. In a second, all plans in the state used the same transportation vendor for non-emergency transportation, though the vendor was paid through the plan. In the other states, plans' efforts related to transportation varied widely, with 1 plan (rural based) having no program, 5 having small/limited programs, typically requiring a referral or authorization and operating at low volumes, and 4 having major programs that are relatively open and user-friendly.

The major transportation programs have a variety of structures, costs, and issues associated with them, and seemed to be responsive to market influences. For example, one plan said its major transportation program was the single biggest factor in its enrollee recruitment strategy. Other plans in its area had not (yet) begun following a similar strategy and tended not to provide much transportation. In another market area, a plan with a small/limited program had scaled back from a major program because other plans in the area had also scaled back such that the market no longer required this for the plan to successfully compete.

Language-Related Services. Most or all plans with a significant non-English speaking population had member services representatives who spoke the needed languages (Spanish, except in one case where 5 languages are involved), printed member materials in the relevant languages,

Targeted Case Management Programs. Ten plans had some form of case management in place (two of these were mixed model plans whose case management programs were only available to enrollees of their staff-model sites). Two were by far the most ambitious programs, each with 5-6 staff devoted to case management of enrollees with targeted conditions like HIV/AIDS, mental health, chronic care, and high-risk pregnancy. One of these plans reported 300 members active in the program, and another reported it had 100 referrals to the program that month on top of its existing caseload. One of these two said even with this level of effort, it is primarily able to do crisis management rather than long-term management.

Case management programs took two main forms:

- ***Case management for members with targeted health conditions.*** Several plans discussed with us their case management programs for pregnant women, or high-risk pregnant women, two had programs for enrollees with HIV/AIDS, three provided case management for behavioral health patients, and two had a case management program for asthma patients (and a third was piloting and asthma program for its staff model patients). Two other plans told us they were developing disease-specific case management programs.

- ***Case managementfor high-risk&gh-cost enrollees defined more broadly.*** Methods used to identify candidate patients for these programs were: recommendations from the hospital discharge planner, provider referrals, tracking of frequent emergency room users, and/or through an initial health assessment process conducted for new members.

Plans varied in what types of staff they used for case management, but several plans used social workers for this responsibility. Case management activities were generally aimed at (1) ensuring the patient was receiving the various services that he/she needed, (2) if not, that the patient was either helped in getting them (if they were covered by the plan) or was helped to apply for them where other agencies or programs might assist, and (3) to ensure the patient was being treated in the least-cost setting.

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Language-Related Services. Most or all plans with a significant non-English speaking population had member services representatives who spoke the needed languages (Spanish, except in one case where 5 languages are involved), printed member materials in the relevant languages,

and offered translation services through AT&T or another similar service. Several plans were in the process of translating materials into additional languages, due to both expansion of their populations, and initiation of new Medicaid program requirements. Only one plan complained about the new state requirements, which in that case required each plan serving a zip code with more than 1500 residents of a particular ethnic background to produce its materials in the native language, even if the plan had few or no members of that ethnic background (in this case, members of the ethnic group in question reportedly gravitate to another plan that has found a niche in catering to this particular population). Other state requirements were based on having more than a threshold number or percent of members in the plan who spoke a particular language (e.g., 10 percent); several plans translated materials beyond the required extent. Two plans had innovative programs involving health education efforts in languages other than English.

Administration of Reminder Systems. Six of the 14 plans discussed having active reminder systems for immunizations, EPSDT visits, and/or mammography screenings. These differ some by plan, but typically use encounter data to identify children whose immunizations are not up to date, for example, which prompts a reminder card or call to the parent, the child's provider, or both.

Other Outreach. Most plans (10 of them) make telephone calls to new members, to welcome them to the health plan, explain basic plan policies such as for emergency room use, and/or encourage them to come in for a health assessment. Many of these plans acknowledged that the success of these contacts is highly limited by the low percentage of Medicaid enrollees who have telephones (e.g., 30-60 percent). Two plans have more extensive outreach efforts to new members, that include visits to member homes, and a third plan is pilot-testing such an effort.

Other types of outreach efforts (each found in one plan) include:

- A system for following up on all those who failed to show up for an appointment or visited the ER.
- Funding a public health nurse to immunize in the homes.
- Outreach telephone calls to enrollees who completed a health assessment form that indicates some risks.
- Sending nurses out into the community (e.g., in grocery stores) to give immunizations.
- Dedicating two staff to working with county eligibility workers to keep enrollees eligible for Medicaid (thus improving continuity of care).

24-Hour Nurse Advice Lines. Five plans had 24-hour nurse advice lines in place (one of these applied only to the plan's staff-model side), and two more were planning for this. In addition, two plans had 24-hour hotlines, which may not have been staffed by RNs (involvement of clinical staff was unclear but the enrollee at least had a point of access). One plan's service included a follow-up call to enrollees to whom advice had been given. This same plan was refining the service so that the advice nurses could fax the relevant information directly to the enrollee's primary care provider.

Health Education Programs. Half the plans emphasized their health education efforts, which included printed materials (e.g., newsletters or new member materials), audio tapes, and classes targeted to specific health promotion topics. We did not assess the quality of these materials, and while we could assume that they are geared to the Medicaid population in the Medicaid-focused plans, one commercial-based plan raised a cautionary note by acknowledging that its materials and newsletter were written at too high a literacy level for Medicaid, though it was in the process of a major effort to revise them (prompted by winning a competitive bidding process where it had proposed to the state to do this).

Targeted Case Management Programs. Ten plans had some form of case management in place (two of these were mixed model plans whose case management programs were only available to enrollees of their staff-model sites). Two were by far the most ambitious programs, each with 5-6 staff devoted to case management of enrollees with targeted conditions like HIV/AIDS, mental health, chronic care, and high-risk pregnancy. One of these plans reported 300 members active in the program, and another reported it had 100 referrals to the program that month on top of its existing caseload. One of these two said even with this level of effort, it is primarily able to do crisis management rather than long-term management.

Case management programs took two main forms:

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- ***Case management for high-risk/high-cost enrollees defined more broadly.*** Methods used to identify candidate patients for these programs were: recommendations from the hospital discharge planner, provider referrals, tracking of frequent emergency room users, and/or through an initial health assessment process conducted for new members.

Plans varied in what types of staff they used for case management, but several plans used social workers for this responsibility. Case management activities were generally aimed at (1) ensuring the patient was receiving the various services that he/she needed, (2) if not, that the patient was either helped in getting them (if they were covered by the plan) or was helped to apply for them where other agencies or programs might assist, and (3) to ensure the patient was being treated in the least-cost setting.

We did not hear any plans talk about case management as a tool for marketing to enrollees. Only one plan, with an intensive HIV/AIDS case management program, expressed concern that it was gaining a reputation for good service in this area and thus was attracting sicker enrollees.

Social work services. Social workers available were available in five plans to help link enrollees with programs to meet needs other than their health care needs (one only on its staff-model side), though plans tended not to emphasize this except in the context of case management (described above).

Other. Other types of access-enhancing services reported by one or more plans (one unless noted)--many of which are aimed at reducing the amount of care provided in more costly settings--included:

- Flexible services provided to disabled enrollees, for example, providing aid visits three times a day for one enrollee.
- Distribution of about 7,000 free thermometers after the plan heard that moms were taking their children to the emergency room in part because they could not assess the severity of their fever.
- Authorization of over-the-counter drug purchases charged to the plan through contracts with area pharmacies.
- Contracts with urgent care clinics, and/or providing 24-hour care in one plan's staff-model sites (3 plans).
- Hiring people from different communities in the service area to "map" out local services and thus enable better coordination of available programs (still in the planning stages).

B. EXAMPLES OF INNOVATIVE APPROACHES

The following provides some examples of the programs we considered intensive or innovative in each area discussed above except for social work, where we did not find intensive or innovative approaches. We also include concerns or issues around their experience that they shared. We do

not include many interesting efforts that were in the planning stages--each of the following has already been implemented.

1. Transportation

One plan pays a vendor $.85 per member per month (in 1996) to provide non-emergency transportation for all the Medicaid members who live in this large, urban county. Members must call 24 hours in advance to schedule their ride, which can be for primary care, specialty care, or dental care. Four vans operate 8 AM to 7 PM, and average around 40 round trips per week, with another 40 provided by a taxi company which provides rides when the demand is too high for the van to cover. The plan notes, however, that the system is currently problematic in that the number of members in the county has been growing, while the transportation vendor's capacity remains the same, requiring frequent use of the more costly taxis (cost for taxis is $9.40 for trips under 15 miles, and $19 for trips exceeding 15 miles). The plan believes that while the county provides bus tickets, this is not a good option, as sick people still have to wait at a bus stop.

A second plan provides taxi service to any Medicaid members who request it before 3 PM the day prior to their scheduled visit (exceptions made for urgent care). The taxi company is under contract and bills the plan monthly on a per-trip basis. According to the plan, in addition to alleviating the "no-show" problem, the system helps prevent the "waiting room clog" that occurs when patients have to rely on friends and family members for transportation to appointments. It also views the service as a marketing advantage. However, the plan says the high use of this has resulted in high costs of $2-3 per member per month. It is considering various cost-cutting options, such as creating regular routes between providers, negotiating per diem or capitated rates, or operating its own minivans or buses.

2. Language-Related Services

One plan has found ways to creatively finance the translation of prevention materials into Spanish. Diabetes education was one targeted area. Initially, the plan was buying insulin from several different companies. A staff member reviewed all the companies' preventive materials, and found one that had some that were very good. The plan agreed to exclusively buy insulin from that company if they would translate the materials into Spanish. The materials were distributed to plan membership the prior year. The same general approach was used for smoking cessation, using the buying power of the plan with respect to nicotine patches. Asthma is the plan's next project, although it is proving more of a challenge.

Another plan maintains an audio health line, where enrollees can call in and hear health-education messages about sensitive topics like AIDS and pregnancy in Spanish as well as English.

3. Reminder Systems

To remind people about needed immunizations, this plan sends a letter to all members with children 15 months of age, and the same letter at 2 years of age. Quarterly, the plan reviews its claims data and to check on immunization status, following up with parents of children who appear to have not received the immunizations. At present, the plan's data is not completely accurate, since some enrollees get immunized at the local health department. However, the plan pays the health department $6.50 per claim for telling the plan what vaccine it gave and to which health plan member. The plan is also working with grant funding with the health department to establish a computerized link to automate the process.

4. Other Outreach

New enrollees to this plan complete a health assessment questionnaire. If they indicate that they have any of a list of high-risk conditions, they get into the plan's outreach program. All pregnancies get into this program. A patient care coordinator (one is a social worker, one is an RN) calls to talk to the patient about their condition and makes sure they secure the medical care they need, assesses their need for transportation (which the plan provides), and their risk status. If pregnant, the patient is also informed about the plan's incentive program, which rewards women who receive early and consistent prenatal care. A formula drives the score so that if a woman gets first trimester prenatal care, and attends 80 percent of her prenatal care visits, she gets the best gifts--an infant car-seat or stroller, as well as the lesser gifts that women get for less compliance. (There are three tiers of gifts.)

Another plan paid the salary for a public health department nurse who was responsible for going out into the community and giving immunizations in the home. The plan did not directly hire the nurse because it views its proper role as an insurance entity not a deliverer of services.

A third plan staffs a special unit with 11 "access specialists" who, among other things, (1) follow up in person with new members who do not have telephones, to welcome them and tell them about the plan, and (2) follow up on enrollees who miss one or more appointments, as providers notify the group of this problem, to arrange for transportation or otherwise help to resolve the problem.

5. 24-Hour Nurse Advice Line

Twenty-four hour advice nurses are empowered at this plan to authorize purchase of over-the-counter drugs to be charged directly to the plan, and authorize transportation by taxi (again, directly charged to the plan) to pick up the items. This procedure was begun because the plan was finding

that members were going to the emergency room because they did not have Tylenol or cough syrup. Several pharmacies in the area are under contract for after-hours service.

6. Health Education Programs

Classes provided without cost or at nominal fee at this plan include smoking cessation, preventive care for members who have had back injuries, teen pregnancy, and nutritional counseling for diabetics. After members complete a health risk assessment (routinely encouraged for new members), they are offered the opportunity to discuss their results with a health educator and are given relevant information at that time. A special unit in the plan works with providers to develop prevention and education programs and materials, e.g., on sexually transmitted diseases, family planning, etc.

7. Targeted Case Management

The plan has one case manager each for HIV/AIDS (for 800-900 HIV positive members), for mental health/mental retardation, and for EPSDT expanded services. Referrals for case management come from utilization management nurses who follow hospitalizations, home care coordinators, member services, and directly from primary care providers. Last month, the plan had 100 cases referred for case management; with this high caseload, the plan does more crisis-management than long-term management, but does link its members with long-term case management resources available in the community.

Another plan has six nurses in the Utilization Management division who function as case managers. Each has 40-75 cases at a time. The case management focuses on mental health, AIDS, pediatric care, chronic care, and prenatal care. Tracking of emergency room users and provider referrals are the main sources of referral to the program.

APPENDIX D

EXTENT OF REMAINING PROVIDER SUPPLY AND ACCESS PROBLEMS

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Although plans and providers generally agreed that the areas they served had an adequate supply of primary care providers, there were a number of community-specific problems which we detail here for policymakers who are focused on understanding provider supply issues. The problems and experience recruiting providers are discussed first from the safety net providers' perspectives, and then from the health plans' perspectives. We also discuss access problems that were not related to provider supply, but that surfaced in our interviews.

A. PROVIDER SUPPLY ISSUES AND EXPERIENCE WITH RECRUITING

1. Safety Net Providers

Primary Care. The safety net providers we visited suggested that some provider supply issues remain in their areas, though a majority (14 of 23) reported their community is not now short of primary care providers willing to serve Medicaid. The types of problems related to primary care were unique to specific communities (each bullet below represents only one respondent), and none was worsened by managed care:

- One provider that is new in an area lacking other safety net providers for primary care (just hospital emergency rooms) reports the wait times for an appointment are nearly two months in some cases, and emergency room use remains high. The provider has been able to secure nurse practitioners (it has not sought physicians) but has experienced some problems with retention.
- One provider reports a shortage of multi-lingual primary care providers
- One reports specific, isolated pockets of underservice in this major city
- One reports only 20 percent of physicians in its service area accept Medicaid; that the only other Medicaid-serving providers besides itself are "Medicaid mills."

- One rural CHC reports problems retaining primary care physicians, though this may be in part due to poor management and frequent leadership changes.

Consistent with this, just over half (11/21) of the safety net providers reported no problems recruiting the primary care providers that they needed. Of the seven that reported problems or difficulties recruiting primary care physicians, only one directly attributed its difficulties to managed care: "managed care has made competition harder for physicians and our salaries less competitive." Three were public health departments or publicly owned and had some unique difficulties because of this; two of the three reported their difficulties were due to financial constraints and problems of their agency rather than supply issues. The others reported their difficulties were related to their location (e.g., in dangerous neighborhoods) (mentioned by 3), provider supply (mentioned by 1 that was in an area with many available specialists but few primary care physicians), and simply their strong preference for certain types of physicians, for example, "we have a tough time finding enough experienced physicians as opposed to recent graduates," and "it is time-consuming to find staff with the right kinds of skills...Medicaid/low-income experience, cultural sensitivity, board certification." Four safety net providers also reported problems with recruiting nurse practitioners and physician assistants, for example, "recruitment of mid-levels is harder--more competition and smaller supply."

Specialty care. A few providers volunteered local provider supply issues with specialists, indicating that some isolated problems remain:

- One CHC reported it is difficult to find referral physicians for sliding scale patients, and that orthopedists and neurologists are needed in the community.
- One is having difficulty recruiting an obstetrician and a mental health professional who speak Spanish
- One reports a serious shortage of mental health professionals in its rural area.

2. Health Plans

The study plans experienced widespread success in expanding their provider networks. Plans reported remarkably few problems building sufficient primary care networks in new service areas and strengthening them within their existing areas. Generally, they report providers are available in adequate supply, are interested in contracting for Medicaid, and tend to contract with most or all the plans in an area. Only the following isolated difficulties were reported with primary care contracting:

- Only two plans reported the supply of primary care providers were a substantial problem--one found such problems in rural areas it was targeting for expansion, the other's problem was specific to a shortage of obstetricians in a small, low-income urban area.
- Five plans reported scattered (infrequent) problems contracting with enough primary care providers because some providers avoided managed care and/or Medicaid, or contracted exclusively with another plan for Medicaid.
- One plan was closely linked with a health system facing extreme financial problems, so that many of its contracted providers were having to implement layoffs; where the contracted providers were having to hire to replace key clinical staff, this was difficult given the organizational turmoil.

A few plans reported making accommodations or changes in their contracting or payment strategy to ensure enough providers throughout the service area. One had to give a couple of key medical groups an enrollment guarantee (with capitation, this is an income guarantee), but has never had to actually pay on such a guarantee. Another plan directly contracts with nurse practitioners and physician assistants in a few rural areas to ensure sufficient access. This same plan has also shared re-location expenses with providers who would move to areas where the plan had not been able to contract with enough primary care providers. In a third case, the plan viewed a particular community

health center as a key provider and proposed an alternative payment approach viewed as favorable by the CHC, because a competing plan had offered fee-for-service payment in return for a near-exclusive relationship with the plan. A fourth plan reported it cannot insist on board certification, nor enforce 24-hour coverage standards in a small urban area where the plan needs all available primary care physicians to be part of its network.

The comments of a rural-based plan suggest the criteria for what constitutes an adequate provider network differ for rural vs. urban communities of necessity given the sparse population and fewer number of providers. The plan noted there are 7 counties in the state with no physician at all, two of which the plan serves. This geographically isolated area lies between mountain passes and has less than 500 people living there. Yet the plan does not view this as a problem... "the people that do live there are tough--it's the culture. We don't see more emergency expenses from these areas, for example, because these people are likely to wander into a primary care office and ask for an appointment three days after dislocating a shoulder." For this plan, working with the area providers to fix access problems as they arise is a normal part of doing business. For example, the plan has dialysis patients who drive 120-160 miles per week for dialysis, because no machines are available any closer than that. Through a cooperative effort, there are now plans to put a dialysis machine in one of the local hospitals.

Also, some plans volunteered (we did not consistently ask) the following additional issues in contracting for specialists:

- Dentists were reportedly difficult to find for the Medicaid population in two plans, and a third plan had problems contracting with dentists to provide care to the mentally retarded enrollees it covers (resolved).
- Mental health providers were largely unavailable in a large portion of one state's mostly rural terrain.

- Dermatologists and ENT's were reported hard to contract with for the Medicaid population in suburban areas, because they tend to avoid both managed care generally and the Medicaid population.

B. ACCESS ISSUES UNDER MEDICAID MANAGED CARE NOT RELATED TO PRIMARY CARE

Plans and safety net providers noted some area-specific limitations in health plan networks, not related to primary care. Though the study's principal concern is access to primary care, which appears to have expanded under managed care, plans and providers did note other area-specific limitations in health plan networks or Medicaid managed care programs that could affect access to those services:

- One plan acknowledged that while access to physician and hospital care is good throughout its (large) service area, in the new, inner-city expansion area, access to ancillary services (home health, pharmacies, physical therapy, medical equipment) are more limited than under fee-for-service.

- A CHC reported concern about home health access in its area, because a health plan had by-passed its home health service, and contracted with a small, distant group; the CHC expressed concern about the contracted group's ability to fulfill its responsibilities in the large, rural territory it was to cover.

- Two traditional providers (in different states) reported that mental health services are more fragmented and/or confused now with the mental health carve-out. A plan in one of the states also raised this issue, and said it had been difficult to sort out the responsibility and payment for the medical side of a psychiatric problem, for example, if the plan responds to a patient's complaint of pain first with tests, then the problem is determined psychological, is the mental health contractor or the plan responsible? Also, the plan noted in some areas of the state, the contracted mental health provider only has the capacity to treat the most severe mental health problems; is the plan then responsible for the more minor problems?

- Three safety net providers (two rural, one urban) reported more problems with specialists than under fee-for-service. One said generally it is hard to get specialists to see Medicaid patients, and two others found isolated problems with particular specialists. For example, the plan has no pediatric neurologists, which are needed for treatment of many of the Center's "crack" babies (care was being given out-of-

network, and this was being fixed). One plan acknowledged its network is limited in some areas by resistance to contracting by area providers.

In sum, our study providers and plans raised some concerns about managed care's effect on access by particular groups needing specialist care or particular ancillary services and living in certain areas with provider resistance to managed care, even though overall, they agreed Medicaid managed care had brought increased access to primary care providers and, many said, to most specialists.

APPENDIX E

CHANGES UNDER WAY THAT MAY AFFECT ACCESS IN THE FUTURE

CHANGES UNDER WAY THAT MAY AFFECT ACCESS IN THE FUTURE

To interpret the study findings, we must assess whether the mostly positive effects of Medicaid managed care on service availability in our study communities are likely to hold for the future. In fact, major changes were under way that--depending on when, how, and how much they occur--could threaten to erase the gains accrued to date. Below, we give voice to respondents' reports and expectations about potential changes and their impact, though neither the ultimate shape of the changes nor their impact are at all certain.

A. STATE MEDICAID PROGRAM CHANGES: MAJOR SHIFTS SUGGEST FUTURE ACCESS COULD BE DIFFERENT

Major state Medicaid program changes under way or planned in the states we studied included more competitive contracting strategies, decreases in capitation rates, enrollment of the disabled/SSI Medicaid population into managed care, and reduced financial protections for FQHCs.

1. Increasingly Competitive State Contracting Policy

State contracting policy was becoming more competitive in many of the markets we studied. The effect of this on access to care likely depends on whether the state is simultaneously moving from a voluntary to a mandatory managed care program and how the state structures the process. If states are selective and exclude existing plans, if access-related incentives or requirements are included in the bidding process, or if the bidding process influences the number and type of providers with which plans contract, access to care for Medicaid managed care beneficiaries could potentially be affected.

Nature of the shift. At the time of our visits, the Medicaid programs in six markets used a "certification" process for contracting with plans that met certain minimum requirements, but were moving to a competitive process more like the other four markets in the study. The programs using a more competitive process issue a request-for-proposal (RFP) and do not guarantee that all qualified plans will be selected. In two states that already had mandatory programs and competitive processes in place, the state was making or expected to make the process more competitive.

Options likely to increase for beneficiaries in six of the markets. A shift to mandatory programs simultaneous with more competitive contracting should result in more health plan options for Medicare in six of the 10 study markets. Experience in the study markets that have already shifted to a mandatory program suggests that the huge volume of enrollees and dollars involved will attract many new plans to the Medicaid market, even as the state's contracting process becomes more competitive. Plans and providers expected this to happen in four of the five markets that now have relatively few plans in the Medicaid market and are shifting to a mandatory program.

Options may decrease in three markets. In one of the states shifting to a mandatory program and two that already have mandatory programs, a more competitive process may decrease the number of plans serving Medicaid, causing some plans and providers in these areas to express concerns about future access.

In one state, respondents were concerned that the disruptions in care that had accompanied previous managed care transitions would be repeated and worsened by the reduction in plan choices beneficiaries would have if the state's recent decision to competitively eliminate a number of plans was implemented. Disruptions in access during transition periods may be most acute for enrollees in staff-model centers who would have to change their providers (this would affect several thousand beneficiaries in one of our study plans). In response to concerns about disruptions in care and plan

complaints about the decision process, the state planning to eliminate several plans from serving large parts of the state was reevaluating its decision at the time of the visit. The disruptions in care reported in Chapter IV that occur during transitions to Medicaid managed care programs could reoccur annually if states pursue a policy of competitive bidding that results in annual changes in the plans serving beneficiaries.

In a second state, executives of one of the winning plans in a competitive bidding process believe that limiting the number of participating plans can improve access. By being assured a critical mass of Medicaid enrollees, the plan is able to exert greater leverage on network physicians to enforce requirements such as access standards. In addition, because of considerable overlap among plan networks in this market as well as in many of the other markets we visited, disruption in patient-provider relationships because of a decrease in the number of participating plans may not be particularly acute for network/IPA model plans as few have exclusive or even semiexclusive agreements with providers, enabling patients to switch plans without having to switch rather than providers.

2. Decreases in Capitation Rates Paid to Health Plans

Five states we visited were rumored to be planning decreases in capitation rates paid to participating health plans to serve Medicaid beneficiaries. Most plans in states that were considering future rate decreases considered the result predictable: either plans would exit the Medicaid market or would cut back on supportive services, despite the purported cost-effectiveness of such services. Alternatively, plans might pass the lower rates paid by the state on to providers, which could drive many of the providers, especially those new to the Medicaid population, to retreat from the market. Whether providers actually retreat may depend on whether the non-Medicaid market can support their income and practice volume at their accustomed or desired level.

3. More Vulnerable Segments of the Medicaid Population Scheduled to be Enrolled in Managed Care

Enrollment of the disabled/SSI Medicaid population was high on the list of concerns about the future effect of Medicaid managed care on access. All the states we visited had plans for implementing mandatory managed care enrollment for the disabled Medicaid population at some point in the future, though none had yet done so.[1] The states agreed that the needs of the disabled population differed substantially from those of Aid for Dependent Children (AFDC) recipients and that the potential for adverse effects if their care is not efficiently and effectively managed by an appropriate network of providers would be greater.

Plans and providers' expressed three primary concerns about serving this population. First, many physicians who now serve the relatively healthy AFDC population might not be interested in serving the SSI population, leaving them to the traditional safety net providers that already serve a smaller percentage of the healthy AFDC population and would suffer from considerable risk selection and possible financial instability. Second, commercial-oriented providers new to Medicaid might serve the SSI population until they realized the difficulty of serving them well and profitable and then withdraw from treating the SSI population, disrupting their care. Third, providers new to Medicaid would serve the SSI population without understanding the more complex medical and social needs of the disabled poor and therefore be unlikely to meet them. Plans were also extremely concerned about the calculation and adequacy of capitation rates for this population and how that could affect short- and long-term provider and plan participation and thus enrollee access.

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[1]In six states, Medicaid officials had delayed mandatory enrollment timetables for the disabled/SSI population; only one state was continuing to pursue its original timetable.

Two plans we visited already served the disabled on a voluntary basis, and a third was committed to serving this population in the near future. Though we did not discuss issues related to serving this population in-depth, our findings that some disabled beneficiaries consider managed care an attractive option (since they voluntarily enrolled), and plans report they sometimes make special efforts to accommodate special needs. One plan emphasized the need for flexibility; for example, the plan authorized home visits three times daily for a particular disabled member. While this represented an uncovered Medicaid benefit, it was found to be more effective than any other course of treatment. A second plan emphasized that, while important, it can be difficult to identify providers with special skills that are willing to serve disabled plan members. In this case, the plan found that its mentally retarded plan members had specific dental needs that were hard to meet. With considerable effort, the plan located a dentist with experience meeting those needs who was willing to serve these plan members on a regular basis. A third plan was not yet serving the disabled Medicaid population, but had been awarded a contract to begin doing so. It planned to provide case management services using nurses from the public health department, as these nurses had extensive experience meeting the social and medical needs of the Medicaid disabled.

4. Future Loss of FQHC Cost-Based Reimbursement for Medicaid

To date, most of the CHCs and FQHCs in our study had not faced a total loss of funds from FQHC cost-based reimbursement or similar state-specific protections. However, most of those facing a shift from voluntary to mandatory managed care enrollment believe that states will eliminate such protections in the future by not implementing special protections when mandatory programs are implemented. They consider this important to how Medicaid managed care will affect access in the future since, with few exceptions, they view FQHC financial protection as crucial to their continued ability to serve the uninsured and provide all users with supportive services not covered

by capitation payments from plans (see Chapter III). FQHC concerns over access to care for the uninsured are compounded by the competitive pressures being felt by other providers that have traditionally served the uninsured, particularly hospital outpatient departments, to reduce uncompensated care, which may lead to an increase in the number of uninsured seeking care from FQHCs.

Though some providers expressed hope that the state would provide additional funds for uncompensated care to replace FQHC protections, they were not confident that the state would provide adequate funds on an ongoing basis. Therefore, providers were pessimistic about their ability to continue serving the uninsured on an unrestricted basis and providing the same level of access-enhancing supportive services to both the uninsured and Medicaid populations.

However, the experience of the CHCs and FQHCs that have faced a loss of FQHC revenue to date suggests that operational changes made by these providers in response to managed care (see Chapter III) may mitigate the effects of such a loss. Clearly, the ability of these providers to continue providing the same level of medical and supportive services in the future to all populations in need will depend on successfully transitioning to a more competitive, information-driven, cost-conscious environment. Of the providers we visited some were in a better position to manage this transition than others.

5. Summary of Key State Changes Planned or Expected

The following major changes in state Medicaid programs have the potential to affect future access, with most having more potential to restrict access and services than to enhance them:

- ***More competitive contracting.*** In markets where a more competitive contracting process was being implemented together with a mandatory managed care program (6 of 10 markets), health plan options for beneficiaries were likely to continue to increase.

We heard greater concerns for future access in three markets where options may decrease as a result of more competitive contracting, though not all those we interviewed agreed on the likely effect on access.

- ***Decreases in capitation rates.*** If rumored decreases in plan capitation rates are implemented, plans warned that access could be diminished as plans leave the Medicaid market or reduce supportive services and providers new to Medicaid withdraw because of lower rates.

- ***Enrollment of the disabled SSI/Medicaid population into managed care.*** Plans and providers we visited expressed a host of access and payment-related concerns about enrolling the disabled SSI/Medicaid population in managed care.

- ***Reduced financial protections for FQHCs.*** Providers were concerned about whether states would continue the current level of financial protections for FQHCs, and if not, whether FQHCs could survive and continue service to the uninsured in the long run.

B. PLAN-LEVEL CHANGES: PRESENT TRENDS LIKELY TO CONTINUE BUT TWO TYPES OF CHANGES BEAR WATCHING

Though many changes that we observed during our study period are likely to continue, two possible changes being planned or considered would change the picture considerably and could have negative implications for access: (1) if plans become more selective in contracting with primary care providers, and (2) if plans aggressively transfer more risk to providers.

1. Likely Continuation of Some Trends in the Study Markets

Some trends--particularly increases in the number of health plans serving Medicaid and new staff-model sites in some areas--are likely to continue in the study markets. Continued increases in the number of plans serving Medicaid were expected in six of the 10 markets due largely to state policy moves, as already described. Though network/IPA model plans dominate today's Medicaid managed care market, mixed-model plans are continuing to add capacity to the health care system by establishing new care sites. In addition to new sites already established (see Chapter II), one of the three mixed-model plans in the study is developing several additional centers based on its

expectations of a substantial influx of new Medicaid members, and because it views staff model as a better way of delivering care to the Medicaid population. Another mixed-model plan which though not included in the study was negotiating a contract with one of the CHCs in the study, is also reportedly planning to add a staff model site in our study area in anticipation of substantial mandatory enrollment.

2. Two Possible Departures from Current Trends or Patterns

Possible shift to greater selectivity in contracting with primary care providers for plan networks. After initially contracting with as many primary care providers as were willing and able to meet credentialing requirements, some plans are considering limiting the number of primary care providers with which they contract. One plan that has a strong market position and an ample supply of competing providers, and is seriously considering contracting only with providers that meet stiffer requirements, including higher language and cultural sensitivity standards, and that currently serve a substantial number of plan enrollees. Another plan cited the costs of administering so many contracts, coupled with expected decreases in capitation rates from the state, as the reason why it may consider contracting with fewer primary care providers in the future. Plan officials noted that this will be in sharp contrast with its previous policy of being "unable to contract with too many primary care providers."

The overall effect of contracting with fewer primary care providers on access to care is unknown. On the one hand, if plans are able to raise their credentialing standards, the result may be better access and quality. On the other hand, access may be impeded if Medicaid members are forced to change primary care physicians. However, since most providers contract with multiple plans and most states allow enrollees to switch plans, the enrollee could choose to switch plans

rather than providers, potentially leaving the more selective plans at a disadvantage in attracting and retaining enrollees.

Possible shifting of additional financial risk to providers. As discussed above, most plans now pay FQHCs and CHCs primary care capitation, limiting their financial risk. However, five plans, notably those with more experience serving the Medicaid population, expressed hope that they would soon be able to shift more risk and responsibility to providers.[2] Based on the pattern for the few plans that now transfer most risk to providers, the shifting of additional risk in the near future could have negative effects on access in one of two ways. It could mean that plans change their contracting preferences to favor larger provider groups and smaller primary care groups affiliated with specialists and tertiary care facilities over smaller primary care groups without strong affiliations. It could also result in a transfer of risk to groups without the ability to manage it appropriately. For example, one plan transferring full risk reported that a group new to Medicaid had developed aggressive medical management practices. As a result, plan staff have found themselves micromanaging individual member cases to ensure appropriate care is delivered. For example, one plan staff member reported having to strongly advise the provider group to arrange for a necessary surgical procedure for a child member to be performed soon and by an appropriately qualified pediatric surgeon.

As they take on more financial risk, a provider group's ability to serve a large volume of Medicaid enrollees and to effectively coordinate all their care will be crucial to its success. Smaller providers (including many of the safety net providers in the study) could affiliate with hospital

[2]It is also possible that the Medicaid-focused plans, which tend to rely on the FQHCs and CHCs more than other plans, would like to transfer additional risk but will only do so as the FQHCs and CHCs position themselves better to manage such risk. Under this conservative assumption, we do not have reason to believe the shift would negatively affect access.

systems and/or other specialty groups, though the trend at present is to affiliate with other like providers. Providers that are unable or unwilling to affiliate may face greater barriers to contracting with Medicaid-serving plans under this scenario, thus undermining their financial stability and potentially threatening access for groups who rely on them.

The view that more risk should be transferred to providers was not shared by two study plans. One plan maintains a strict policy of transferring risk for services to a provider group only if those services are provided by the group itself. This differs from the policies of other plans in its market. The second plan, located in a less-mature commercial managed care market, found that some providers strongly preferred fee-for-service payment. Although it currently pays providers capitation rates for primary care, next year it intends to follow other plans in its market by offering fee-for-service payment as an option. Thus, in the foreseeable future increased transfer of risk is not likely to occur everywhere.

C. TREND TOWARD INCREASED PROVIDER SUPPLY AND COMPETITION LIKELY TO CONTINUE: SHORT-TERM EFFECT LIKELY POSITIVE FOR ACCESS

Competition for the Medicaid managed care population among primary care providers is likely to continue to increase, since more primary care providers were expected to enter the Medicaid managed care market in all but one of the study areas. In six areas, hospitals that have begun to "convert" their outpatient clinics to primary care centers are expected to continue to do so, building new primary care sites as well. And, as previously mentioned, a few health plans are planning to build new health centers, while in some cases will directly compete with existing plan network providers. This suggests that the benefits for access from an increased supply of providers serving Medicaid are likely to continue to grow at least in the short term.

However, the increased competition will likely spell trouble for some safety net providers that were fairing well to date, since competition was a major problem for the safety net providers that were struggling. Increased competition could also mean improved access if safety net providers are continue to add sites and increase hours. Thus, the net effect on access for Medicaid enrolles from increased competition is unclear.

D. SAFETY NET PROVIDERS' MANAGED CARE CONTRACTING STRATEGIES AND NEW ALLIANCES: SUCCESS OF THESE STRATEGIES IS CRITICAL TO THEIR CONTINUED VIABILITY

Most of the health centers we visited were pursuing additional managed care contracts to protect against the loss of Medicaid patients as Medicaid managed care continues to expand. At the same time, some were also participating in FQHC-based health plans and creating formal provider networks of FQHCs.

1. Shifts in Providers' Managed Care Contracting Strategies

At the time of the visits, virtually all of the many health centers with a history of selective contracting with one or two plans were pursuing additional contracts to protect against the loss of Medicaid patients as Medicaid managed care continues to expand. Even the health centers that had been allied exclusively with FQHC plan were expanding their involvement as with other health plans. Because the health plans we visited were nearly all interested in more FQHC contracts, we would expect that the FQHCs could easily increase their health plan contracting. However, several health centers will likely face greater difficulties as they try to expand their managed care involvement because they are perceived as having strong allegiances to a particular health plan and competing health plans fear that enrollees might be converted to the ally plan.

Alternatively, in two areas we visited, providers that were competitively well positioned and had many contracts were considering contracting with fewer plans. For example, one health center that currently contracts with 11 health plans (four Medicaid and seven commercial) is the dominant provider in a high-density Medicaid area; it may turn the tables on the health plans and request that they bid for the health center's participation. In seeking to work with fewer plans as motivating factors providers cited both the costs of administering so many contracts, especially meeting plans' different administrative requirements, and the desire to exert greater leverage by offering exclusive or semiexclusive contracts.

2. Forming Alliances With Other Providers

FQHC-based health plans are presently supporting FQHCs in several markets we visited, though their futures are far from certain. Health plans formed by or oriented toward FQHCs were operational in four of the 10 markets we visited; two of these plans had been operational for at least a decade, while several others had been established since 1993. In one other market, a county-run managed care contracting entity composed of FQHCs and other public sector entities was expected to be operational soon. Although most health centers in these areas described their contracts with the FQHC plan as more favorable than the alternatives, competitive pressures are leading many of them to contract with other health plans in order to protect their share of the Medicaid market.

The FQHC plans in all four markets were also facing stiff competition. Mandatory enrollment and associated default assignment rules for Medicaid managed care have hurt FQHC plans in two markets, while a third has been struggling with competitive bidding that threatens its foothold in several markets across the state.

Formal provider networks comprised of FQHCs were operational in one market and pending in another. Health centers in these markets were divided over whether such alliances were

advantageous. Those in favor of the network approach see it as a way to achieve more favorable contract terms and to benefit from economies of scale through group purchasing and shared administrative functions. But one health center complained that contracts negotiated through their network are less favorable than those the health center negotiates on its own and that the network process takes much longer. Another health center is worried about being pushed into taking on too much risk and thinks its special mission and unique practice style may be harder to sustain if it forms an exclusive alliance with larger and more traditional health centers.

Another strategy has been to form stronger ties with area hospitals. This approach has helped some health centers gain a better competitive position in the market, though one center's ties to a hospital-based plan have limited its ability to contract with other health plans in the market. For the most part, health centers have resisted formalizing these hospital links, largely because they benefit from having ties to all the hospitals their patients use. One health center financed a major clinic expansion with a loan from one of two fierce hospital competitors in its market; in exchange the health center agreed to be more loyal to the hospital in its referral patterns. The benefits of linking to a hospital may be greater in isolated rural areas; the most isolated rural safety net provider we visited had affiliated with a hospital and found the extra resources and expertise very helpful.

In sum, the long-term outlook for the FQHC-based plans and the provider networks that are forming is uncertain. Failure of these alliance strategies would certainly affect FQHCs' future viability.

E. CONCERN FOR THE UNINSURED POPULATION IN A MORE COMPETITIVE ENVIRONMENT WITH LESS FINANCIAL PROTECTION FOR SAFETY NET PROVIDERS

Many providers and some health plans expressed serious concern about whether Medicaid managed care would reduce access for the uninsured population in the future. Although most safety

net providers have been able to sustain enabling services and uncompensated care thus far, they are worried that declining Medicaid managed care revenues and the loss of cost-based reimbursement protections will force cuts in these areas in the future. Although to date Medicaid managed care has resulted in *increased* supportive services overall and no decrease in safety net services, most viewed the Medicaid managed care program as designed to *shift* these services from the safety net providers to the health plans--a move the safety net providers fear would decrease access in their communities for both Medicaid enrollees and the uninsured populations that also rely on them.

Safety net providers also fear they will face an increased burden of uncompensated care from two sources. First, market pressures--in part due to Medicaid managed care--may be reducing the willingness of private providers to deliver uncompensated care. For example, one FQHC suspected that a neighboring hospital had made a subtle shift to reduce its uncompensated care burden: it would treat any uninsured patient who came to its emergency room, but now steers the patient to the FQHC rather than its own outpatient clinics for follow-up care. Second, welfare and other reforms are expected to increase the number of uninsured seeking care at FQHCs, as state and local programs for the uninsured are being cut back.

In sum, the FQHC program's cost-based reimbursement, current state protections for safety net providers, and/or reasonable rates from preferred managed care plans have allowed safety net providers to continue their traditional level of service to the uninsured thus far. The competition for Medicaid enrollees has even led to increases in availability of services for the uninsured in many areas as providers have added sites and expanded hours. However, the likelihood of a more difficult financial future, together with the prospect of an increased burden of uncompensated care, has forced many providers to think about difficult choices they may need to make to cut access-enhancing

services, eliminate medical services such as on-site ancillary care, and/or limit the amount of care they provide to the uninsured.

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